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Experiences of Serving Personnel and Veterans Conceptualising their Difficulties and Accessing Mental Health Services

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Introductory Chapter

This thesis explores various factors that impact accessing services for mental health difficulties within Armed Forces serving personnel and veterans. There are approximately 2.4 million veterans estimated to be residing within Great Britain (Ministry of Defence [MOD], 2019) and 18 million veterans in the United States (US; US Census Bureau, 2018). It is documented that veterans have a higher prevalence of mental health difficulties than the general population (VA Department of Veterans Affairs, 2018). This increased risk of developing mental health difficulties may be due to exposure to traumatic events (Vogt et al., 2014), although the explanation is more complex and there are likely multiple factors.

Common mental health disorders (CMDs) are the most prevalent mental health condition (21.9%) in UK Armed Forces personnel, followed by alcohol misuse (10%) and post-traumatic stress disorder (PTSD; 6.2%) (Stevelink et al., 2018). This illustrates an increase in CMD and PTSD compared to a previous representative study which reported CMD and PTSD at 19.7% and 4% respectively (Fear et al., 2010). In US, PTSD prevalence estimates range from between 11% and 30% depending upon service era (VA Department of Veterans Affairs, 2018). However, within a help-seeking veteran population, PTSD is the most reported mental health difficulty (82%, Murphy, Ashwick, Palmer, & Busuttil, 2019). Consequently, a global increase in the diagnosis of military-related PTSD has been documented (Chandra et al., 2011). In addition to the prevalence rates above, within the UK Armed Forces TBI prevalence is estimated to be 4.4%, rising to 9.5% in those with a combat role 9.5% (Rona et al., 2012) and co-morbidity of health outcomes is high within military population (Murphy et al., 2019). Nevertheless, it is estimated that 60-80% of Armed Forces personnel with a mental health difficulty do not seek help (Hines et al., 2014; Sharp et al., 2015), and of those that do, they often experience poorer treatment outcomes than the general population (Murphy et al., 2017).

Mental health beliefs and models of health and illness are subjective (Hughner & Kleine, 2008), and are an important predictor to accessing mental health care for this population (Vogt, 2011). Holding negative beliefs about mental health and mental health services, or having normalising beliefs is a barrier to accessing support (Pietrzak et al., 2009; Seigel, Dors, Brants, Schuy, & Rau, 2018; Vogt, 2011).

Chapter one is a narrative review of serving personnel and veteran's beliefs and conceptualisations of PTSD. It explores how serving personnel and veteran populations attribute their PTSD experiences and their beliefs and attitudes towards it. This review draws upon quantitative, qualitative and mixed method data published since 2000 to present day to synthesise available data regarding this topic.

Chapter two consists of an IPA study exploring how UK veterans experience accessing mental health services, when they have mental health difficulties, alcohol misuse and a traumatic brain injury (TBI) acquired during their time in service. This study aimed to strengthen previous literature on help-seeking, exploring barriers and facilitators within this population. Following on from the narrative review, this study also explores the beliefs and conceptualisations of veterans with these multi-morbidity experiences. The empirical paper will be submitted to the British Journal of Psychology for publication (Appendix A for author guidelines).

It is acknowledged that there are debates about the language of understanding traumatic experiences, with differences in medicalisation versus a psychological approach. However, for the purposes of this thesis the term 'PTSD' will generally be used for consistency of language throughout and alignment with the literature base on veteran experiences. Other terms and definitions of understanding may be used when discussing different approaches where necessary.

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Chapter One: Narrative Review

A narrative review of veterans and military personnel's conceptualisation of PTSD

Abstract

Objectives: This narrative review aimed to explore serving and veteran's beliefs about PTSD and how they conceptualised their experiences.

Method: A search was completed in order to identify studies published since 2000 to present day through four databases: Medline, PsycINFO, PubMed and CINAHL. Search terms encompassing 'veteran' or 'serving personnel', 'PTSD' and 'beliefs' or 'attitude' were used. Inclusion criteria included peer-reviewed articles, written in English and focused on the individual's beliefs about PTSD.

Results: 11 articles were included in the review: four quantitative, six qualitative and one mixed method studies. There was variance in the conceptualisations of PTSD and divided beliefs about receiving a diagnosis within the samples. The findings of this review align with the key elements of the Self-Regulation Model. Most studies consisted of among male US Army veterans and therefore, have implications for generalising the review to other serving and veteran populations.

Conclusion: Both medical and psycho-social conceptualisations of PTSD were endorsed. This review will help clinicians working with serving and veteran populations to consider the numerous factors impacting their models of PTSD. Beliefs about PTSD may be modified, and therefore are well placed to be central in a targeted approach to reduce barriers and anticipated stigma, and improve help-seeking.

Key words: Veteran, military personnel, PTSD, attitudes, conceptualisation, health beliefs

Introduction

The term post-traumatic stress disorder (PTSD) originated in the US in the context of military experiences, and has been an evolving diagnosis with changing terminology following different war eras, e.g. shell shock, combat fatigue and PTSD (Kilshaw, 2008). This evolution in the context of society is summarised by Shephard (2000),

"Every war is different. Every time there is a war, different social attitudes to fundamental questions like fear, madness and social obligation will redefine the role of military psychiatry in a different way. Medicine will be different; and symptoms; so, too, will military and institutional circumstances" (xxii).

PTSD has been described as a culture-derived diagnosis, emerging from the post-Vietnam American culture (Young, 1995). Therefore, PTSD is an interaction of trauma and culture, moulded by psychological processes, advances in technology, blame and guilt, and the post-war experiences of the military personnel who fought in Vietnam (Bracken, 2001; Young, 1995).

According to the diagnostic and statistical manual DSM-5 (American Psychiatric Association [APA], 2013), PTSD is characterized by four symptom clusters that include re-experiencing the traumatic event through spontaneous memories, flashbacks and nightmares, avoidance of any reminders, negative cognitions and mood, and hyperarousal such as irritability or self-destructive behaviour. This can be understood in terms of the 'fight' and 'flight' responses. PTSD was re-categorised in the DSM-5 and incorporated in a new chapter on 'Trauma- and Stress-or-Related Disorders' (APA, 2013), after previously being included in the anxiety disorders chapter.

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The clinical entity of PTSD has been debated; whether it is a distinct entity or a medicalisation of human difficulties (Breslau, 2004). Nevertheless, it has become the dominant cultural model in Western societies to understand difficulties relating to traumatic experiences for many years (Breslau, 2004). PTSD can develop after exposure to actual or threatened death, serious injury or sexual violation. This includes military combat, assaults and accidents. Living with PTSD causes clinically significant distress and impacts key areas of functioning such as work and social interactions. However, more recently the development of the 'Power, Threat, Meaning' framework has acknowledged the negative impact that medicalising human experiences can have on individuals, and offers an alternative framework to understanding distress. This framework emphasises the link between wider social factors, trauma and the resulting emotional distress (British Psychological Society; BPS, 2020).

Prevalence of PTSD is documented to affect 7.6% of OEF/OIF veterans in US (Smith et al., 2008) and 6.2% in the UK (Stevelink et al., 2018). Common mental disorders (CMDs; such as depression and generalised anxiety) are more prevalent within veterans (21.9%, Stevelink et al., 2018). However, PTSD is the most reported mental health difficulty within a help-seeking veteran population at 82% (Murphy, Ashwick, Palmer & Busuttil, 2019).

Terminology of PTSD is debated within the military. Due to the stigma associated with PTSD in the military (Coleman, Stevelink, Hatch, Denny & Greenberg, 2017), many veterans and soldiers are reluctant to seek help. Consequently, there is a movement within the military to change PTSD to post-traumatic stress injury, believing that this is more in line with military terminology and would help reduce stigma of a 'disorder'. Whereas oppositions to this believe that the military environment should change to facilitate stigma reduction and promote accessible mental health care. Additionally, the terminology of 'injury' has been argued to be too imprecise a word for what can be considered a medical diagnosis (APA 2013).

Various models have been used to understand beliefs about illness. Ehlers and Clark (2000) proposed a cognitive model which is consistent with the clinical features of PTSD. It is suggested that PTSD develops as a consequence of perceiving threat as a serious threat, arising from excessively negative appraisals and a disturbance in autobiographical memory (Ehlers and Clark, 2000). The Health Belief Model (HBM) is a conceptual framework for health decision-making (Rosenstock, 1966). This focuses on the beliefs and attitudes of individuals, and states that health-related behaviour is influenced by factors such as: susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. The self-regulation model (SRM; Leventhal and Coleman, 1997; Leventhal et al., 1999) characterises health beliefs using five factors: identity (label and symptoms), causal explanations, perceived controllability, perceived course, and consequences on the individual's life.

Lay models of health and illness can vary (Hughner & Kleine, 2008). An individual's conceptualisation of mental health experiences can be influenced by many contextual factors, as there are a lack of objective markers like there are for other illnesses, e.g. infectious diseases (Bhui and Bhugra, 2002; Karasz, Sacajiu & Garcia, 2003). Consequently, lay models are unique to each individual and could fall within the medical or psychosocial conceptualisations. Health beliefs are key as they contribute to help-seeking, treatment adherence and clinical outcomes (Brown et al., 2001; Lobban et al., 2003; Sullivan et al., 2003).

This review does not aim to address the controversy surrounding PTSD as a diagnosis. As noted, there are different ways that post-traumatic stress experiences are conceptualised: medicalised as a disorder and an expression of human emotion due to psychosocial factors. This review did not restrict the inclusion criteria to studies that took only one of these approaches. Despite the varied terminology, debates regarding its clinical

conceptualisation, development of the diagnosis criteria and its link to accessing services, there is no review summarising PTSD beliefs of military and veteran populations. Consequently, this review focuses on veteran and military personnel's own beliefs to better understand the way PTSD is conceptualised by those experiencing it. This understanding may help service providers understand veterans/personnel's perspectives and facilitate service engagement.

Research Question

The overarching aim of this review was to address the question: how do veterans and military personnel conceptualise PTSD?

Additional sub-questions included:

1. Do serving personnel and veterans have different beliefs about PTSD?
2. Are there cultural differences across countries?
3. Are there gender differences in how people conceptualise PTSD?
4. Are there any differences dependent upon which war era the veterans/military personnel were part of (Vietnam, Gulf war, Afghanistan and Iraq)?

Method

A narrative review was conducted to ensure all relevant studies exploring the research question were synthesised, including both qualitative and quantitative literature (Popay et al. 2006; Snilstveit, Oliver & Vojtkova, 2012).

Search strategy

To identify articles that explores veterans' beliefs about PTSD and how it is conceptualised, a literature search was conducted using four databases; Medline, PsycINFO, PubMed and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Key search terms were used to cover the three aspects of this review: veterans and military personnel, PTSD and beliefs. These search terms were created through consultation with supervisors, one of which specialises in the research of military and veteran populations, a specialist librarian and previous reviews on this population and PTSD. The following terms were used:

1. Veteran* OR militar* OR army OR navy OR "armed forces" OR "air force" OR marines OR soldiers OR reserves OR "serv* personnel" OR "ex-serv* personnel"
2. "post?traumatic stress disorder" OR PTSD
3. Belief* OR attitud* OR perspect* OR "illness cognitions" OR "illness perception"

The reference lists of studies, which meet the inclusion criteria, was searched and checked for further relevant cited articles.

Table 1

Inclusion and exclusion criteria for the review

Inclusion Criteria	• Peer reviewed articles • Published since 2000 • Published in English • Focused on PTSD • Qualitative or quantitative articles that report on veteran or military personnel's beliefs and attitudes about PTSD and the meaning of PTSD for them • Qualitative papers where key themes identified beliefs or attitudes of PTSD • Identified the individual's beliefs – not family or professional
Exclusion Criteria	• Articles published in non-English languages • Published before 2000 • Case studies – including a single participant • Focus on broader physical or mental health / general health in those with PTSD • Grey literature such as books, dissertations, conferences • Focus on common mental health conditions e.g. depression and anxiety • If the study only explores PTSD in other professions e.g. emergency workers • Studies which focus on the symptoms of PTSD e.g. using the PTSD checklist • Articles that report beliefs and attitudes towards help-seeking • Articles focusing on the impact of an intervention • Reviews • Qualitative studies where the only relevant section is a subtheme in the data • If the paper only asks about positive experiences e.g. post-traumatic growth • Articles which focus on moral injury

Selection process

The search was completed in February 2020. Search results identified by the four database searches were imported and organised in EndNote Online. Titles and abstracts were screened against inclusion and exclusion criteria (Table 1). Full-texts were acquired for all

abstracts that appeared to meet the inclusion criteria or where there was uncertainty. Full-texts were then screened for inclusion. A PRISMA flow diagram (figure 1) below presents the information on the number of studies identified, screened, included for data synthesis and excluded. The lead researcher was responsible for screening titles, abstracts and full-texts against inclusion and exclusion to decide upon the final included papers. An independent reviewer screened a proportion (10%) of articles at each stage. Any disagreements were resolved through discussion until a consensus was reached.

Data extraction

Data extraction included: title and date of study, author/s, year the research was undertaken, country, sample size, study population, methodology used, any self-report questionnaires used and response rate where relevant, key results/themes, author comments and initial reviewer comments.

Data Analysis

The review yielded both qualitative and quantitative data and a narrative review is good for diverse designs when studies included are insufficiently similar to make direct comparison (Popay et al., 2006). To develop a synthesis of the key factors answering the research question, the researcher tabulated data by study and summarised the identified factors of interest. The studies were then organised into themes based on the health models to help frame their experiences and capture relevant beliefs for the research questions.

Quality assessment

The Quality Assessment Tool for Studies with Diverse Designs (QATSDD) was used to assess study quality (Sirriyeh, Lawton, Gardner & Armitage, 2011), allowing the standardised comparison of qualitative and quantitative studies (Appendix B). The 16-item

tool is often used in the disciplines of psychology, sociology and nursing. The QATSDD has good reliability and validity for use in the quality assessment (Sirriyeh, et al., 2011). A higher the score suggested a greater quality of research.

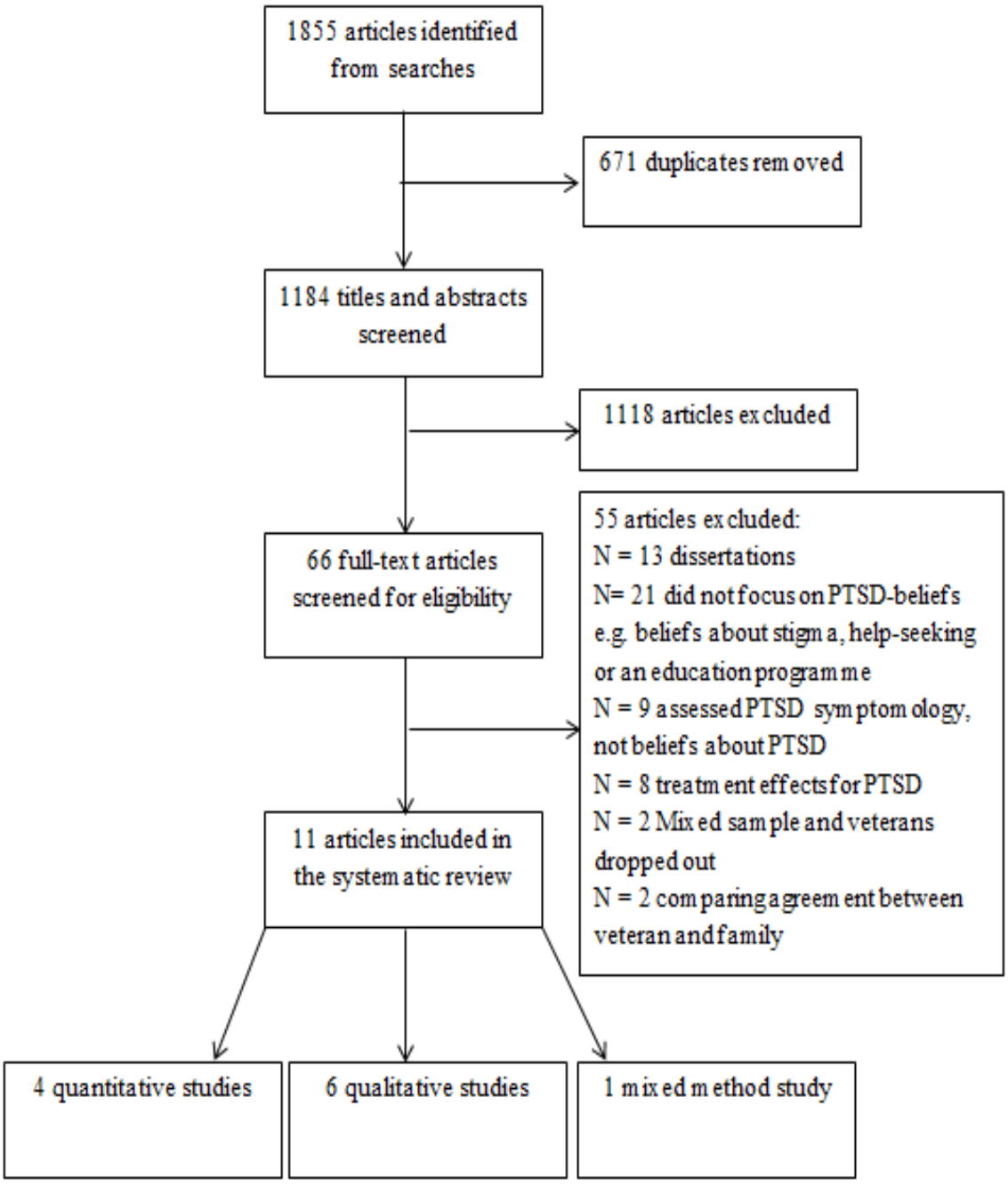

Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram (Moher, Liberati, Tetzlaff & Altman, 2009).

Results

Study characteristics

This review yielded 1855 articles, 671 of which were removed due to duplication. After applying the inclusion and exclusion criteria to the full-texts, 11 studies were deemed relevant to the research question and included in the review. Studies varied in their design and aim (Tables 2 and 3 for study characteristics), however all reported relevant information to the research question, identifying beliefs, attitudes or attributions associated with PTSD.

The included articles were published between 2005 and 2020, and the majority (10 out of 11) were conducted in US. There was a mix of methodological approaches to data collection to explore and examine beliefs and attitudes towards PTSD; four quantitative studies, six qualitative studies, and one mixed methods. One study categorised themselves as a mixed methods approach, but only reported data relevant to participant characteristics (e.g. mean and ranges of trauma, alcohol use and anger), thus has been documented as a qualitative study for the purposes of this review (Sherman, Gress Smith, Straits-Troster, Larsen, & Gewirtz, 2016).

All quantitative studies collected data indirectly via surveys. There were a variety of measures utilised, however the most frequently reported measure was a version of the post-traumatic stress disorder checklist (PCL), which was used in four studies; two qualitative, one mixed methods and two quantitative (Currier, Lisman, Harris, Tait, & Erbes, 2013; Sherman et al., 2016; McGaw, Reupert, & Maybery, 2018; Possemato, Johnson, Wray, Webster, & Stecker, 2018).

Of the qualitative data gathered, various approaches were utilised for data collection: individual face-to-face interviews, focus groups and written letters. Analysis methods also

varied between these studies, using content analysis, thematic analysis, constant comparison methods and a phenomenological approach.

Sample sizes ranged from 10 to 372 between all studies. The quantitative studies ranged from 84 to 372, the qualitative studies ranged from 10 to 44, and the mixed method study had a sample size of 27.

Participant characteristics

All but one study consisted of veterans; one focused on serving military personnel (Hardy et al., 2020). Ten studies had a male predominant sample, whereas one study specifically explored female veterans' experiences (Haun, Duffy, Lind, Kisala, & Luther, 2016).

From eight studies which reported an average age of their sample (Spoont, Sayer, & Nelson, 2005; Currier et al., 2013; Haun et al., 2016; Price, MacDonald, Adair, Koerner, & Monson, 2016; Harik, Matteo, Hermann, & Hemblen, 2016; Sherman et al, 2016; McGaw et al., 2018; Hardy, Kennedy, Reid, & Cooper, 2020), the average age overall was 45 years, with a standard deviation of 10.32 (McGaw et al., 2018 reported mean age and age range, not SD). Five studies reported age ranges (Spoont, Hodges, Murdoch, & Nugent, 2009; Haun et al., 2016; Hayes, Degeneffe, Olney, & Tucker, 2017; McGaw et al., 2018; Possemato et al., 2018). The overall age range of participants was between 20 – 71 years.

PTSD symptomology was assessed by various versions of the post-traumatic checklist (PCL). Two studies used the PCL-civilian version (Currier et al., 2013 and Sherman et al., 2016), one used PCL-specific, which is a version of the PCL but asked in relation to a specific event (Possemato et al., 2018) and one used PCL-version 5 (McGaw et al., 2018). All PCL questionnaires are 17-item self-report scales. The average score on PCL questionnaires

was 50.37 (S.D=11.29). McGaw et al., (2018) reported that participants reached threshold for a PTSD diagnosis, but they did not provide the mean and standard deviations and therefore are not included in the averaging of this.

Table 2

Study Characteristics for Quantitative Studies: Author, Date, Country, Design, Aims, Recruitment, Sample information, Measures and Analysis

Study and Location	Design	Aims	Recruitment	Sample Information	Measures	Analysis
Currier et al., 2013 US	Quantitative Self-report postal questionnaires	To examine the role of cognitive processing and attitudes toward trauma disclosure among newly returned veterans of the Iraq and Afghanistan wars.	Recruited from VA sites. Contacted via phone then mailed. 182 agreed to receive questionnaires (60% response rate)	110 veterans Average age: 31.18% (S.D=9.71 80% male 100% deployed 82.7% Army 92.7% Caucasian Average 1.4 years education 40% married	The Combat Exposure Scale (CES) The Cognitive Processing of Trauma Scale (CPOTS) The Posttraumatic Stress Disorder Checklist Civilian version (PCL-C). The Beck Depression Inventory II (BDI-II).	Means, standard deviations, and bivariate correlations. Three hierarchical regressions.
Hardy et al., 2020 US	Quantitative Self-report questionnaires	To evaluate the degree to which military service members with a history of mild TBI attributed posttraumatic symptoms to TBI versus PTSD.	Brooke Army Medical Center. Recruited from primary and specialty care clinics and health screening fairs.	372 serving personnel Average age: 36.3 (S.D=7.9) years Current PTSD diagnosis: 42.7% 86.8% male 80.1% white Average years in service: 14.4 91.4 Army 79.3% higher than high school education	Neurobehavioral Symptom Inventory (NSI). Questionnaire developed to rate attributions: "Considering your current symptoms, how much do you think that they are due to each of the following: TBI, pain, lack of sleep, PTSD, depression, deployment-related stress, or readjustment stress?"	Odds ratios, Z scores, p values, Means and 95% confidence intervals. Two-tailed analysis of variance to compare means across groups. Logistic regression analysis to explore contribution.

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Study and Location	Design	Aims	Recruitment	Sample Information	Measures	Analysis
Harik et al., 2016 US	Quantitative Online survey	To examine what people with PTSD symptoms know about PTSD and its treatment.	Drawn from an online research panel (GfK Group). Survey was open from 27th May 2015 through 25th September 2015. 2,655 panel members were randomly recruited via email. 73.2% (1944) responded, 81.7% ineligible. 55 removed when quota was full.	301 participants 49.5%% veterans Average age: 49.11 (S.D=16.21) years 63.8% male (actively recruited females) 60.1% white 83.7% no prior PTSD treatment 67.8% at least college level education 59.5% married or cohabiting	Primary Care-PTSD screen PTSD knowledge questionnaire	Descriptive statistics for demographic variables and mean scores (% correct). Linear regression models.
Possemato et al., 2018 US	Mixed methods Concurrent triangulation design Self-report measures Four 90minute focus groups	To understand the psychosocial concerns, treatment barriers, and treatment facilitators among non-treatment-seeking primary care veterans with PTSD who reside in both rural and urban settings.	Recruited from primary care. Identified on medical records, and then sent a letter. Researchers followed up with a call.	27 veterans 23 male 85.2% white Age range: 26-71 years 74.1% had probable PTSD 55.6% served in Vietnam 22.2% served in Iraq/Afghanistan 10 had no prior MH use / 11 attended 1-3 sessions 66.7% employed Average 15.1 years of education (S.D=3.6)	The PTSD Checklist–Specific PHQ-9 Perceived Stigma and Barriers to Care (PSBC)	Chi-square tests Independent sample t tests

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Study and Location	Design	Aims	Recruitment	Sample Information	Measures	Analysis
Spoont et al., (2005) US	Quantitative Self-report postal questionnaires	To examine health beliefs and what factors influence decisions about PTSD treatment.	Had a disability examination between 1997 and 1999 at the Minneapolis VA Medical Center. Medical records checked for PTSD diagnosis. Mailed letter, then the questionnaires, then a reminder. Of the 145 potentially eligible subjects, there were 84 usable surveys (58% response).	84 veterans Average age: 61.6 years (S.D=12.9) 100% PTSD diagnosis PTSD symptoms for average of 31 years (S.D = 16) 95% male 74% married 89% white 78% unemployed 55% college level education	Illness Perceptions Questionnaire Treatment Appraisal Questionnaire	Univariate logistic regression analyses at $p < 0.1$ due to small sample size. Multivariate logistic regression analyses. X2 tests and t-tests

Table 3

Study Characteristics for Qualitative Studies: Author, date, country, aims, recruitment, sample information, data collection and analysis

Study, Date and Location	Design	Aims	Recruitment	Sample Information	Data Collection Methods	Analysis
Haun et al., 2016 US	Qualitative	To explore the impact of PTSD on female veterans' health-related quality of life.	Veterans receiving treatment at three large VHA medical centers (Massachusetts, Minnesota, and Florida).	12 veterans 100% in treatment for PTSD Average age: 47 (SD=12), range of 29-66years 83.3% deployed 100% female 91.7% white 50% divorced 83.3% had college education	Semi-structured focus groups. 3 groups of two – six participants. Lasted one hour.	Content analysis
Hayes et al., 2017 US	Qualitative	To document perspectives of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans with posttraumatic stress disorder (PTSD) regarding their efforts to move from homelessness to employment.	Residential veteran-focused programme in a large city in the southwest United States. Recruited at the employment and training section. Provided a letter to those eligible. Participants expressed interest. Recruitment took three months.	10 OEF/OIF veterans Age range: 25 – 35 years 100% met Department of Defence definition for PTSD 100% in residential programme 80% male 60% white 60% Navy 50% separated/divorced 60% college/school experience	Semi-structured interviews.	Phenomenological

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Study, Date and Location	Design	Aims	Recruitment	Sample Information	Data Collection Methods	Analysis
McGaw et al., 2018 Australia	Qualitative	To explore veterans experiences of family life and parenting within the context of his or her PTSD.	Ongoing purposive sampling, self-selection and snowballing sampling. Use of Facebook, website, flyers in waiting rooms of mental health services and practitioners provided information to clients. All but two were recruited through online advertising.	11 veterans Average age: 43 Age range: 31 – 51 years 100% in treatment for PTSD as a result of military service 100% diagnosed PTSD 9 male 100% deployed 7 had single deployment Time in the military: 4-26years 7 married 10 Caucasian 8 unemployed	Individual semi-structured interviews	IPA, but also references methodology by Braun and Clarke (2006)
Possemato et al., 2018 US	Mixed methods Concurrent triangulation design	To understand the psychosocial concerns, treatment barriers, and treatment facilitators among non-treatment-seeking primary care veterans with PTSD who reside in both rural and urban settings.	Recruited from primary care. Identified on medical records, and then sent a letter. Researchers followed up with a call.	27 veterans 23 male 85.2% white Age range: 26-71 years 74.1% had probable PTSD 55.6% served in Vietnam 22.2% served in Iraq/Afghanistan 10 had no prior MH use / 11 attended 1-3 sessions 66.7% employed Average 15.1 years of education (S.D=3.6)	Four focus groups	Content analysis

EXPERIENCES OF ACCESSING SERVICES

Study, Date and Location	Design	Aims	Recruitment	Sample Information	Data Collection Methods	Analysis
Price et al., 2016 US	Qualitative	To examine patients' appraisals of their traumatic experiences and trauma-related beliefs to better understand the outcomes and mechanisms of CPT.	Subset of participants from a randomized controlled waitlist trial of 60 individuals diagnosed with military-related PTSD. Participants were those with complete impact statements.	15 Average age: 52.87 (SD=6.61) Military-related PTSD 87% male 67% married 80% Vietnam veterans	"Impact statements" written after sessions 1 and 11 describing their appraisals of their trauma and beliefs potentially impacted by traumatic events.	Thematic analysis
Sherman et al., 2016 US	Qualitative 7 individual interviews and 3 focus groups	To examine veterans' perspectives on (a) the impact of PTSD on parenting, and (b) their children's reactions to their behaviour. Veterans' interpretations and perceptions of their parenting behaviours associated with their PTSD.	VA centres – 3 sites (Oklahoma City, Oklahoma; Minneapolis, Minnesota; Phoenix, Arizona).	19 veterans Average age: 39.10 (S.D=6.90) years Age range: 27-52 100% diagnosis of PTSD 89.47% male 82.20% white 52.63% married or cohabiting 82.40 unemployed 52.63% college graduate 82.40% deployed	Focus group or individual interviews	Inductive analysis.

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Study, Date and Location	Design	Aims	Recruitment	Sample Information	Data Collection Methods	Analysis
Spoont et al., (2009) US	Qualitative	To explore how some veterans come to view their reactions and adaptations to traumatic events as reflecting (or possibly reflecting) a clinical diagnosis of PTSD.	Stratified purposeful sampling. Veteran PTSD claimants were obtained from the Upper Midwest Veterans Benefits Administration. Mailed a letter to eligible veterans. Of the 220 potential participants, 118 (54%) indicated interest in being contacted, 44 were eligible and interviewed.	44 veterans Age range: 20-62 100% PTSD claimants 48% in treatment at the time 50% Iraq/Afghanistan conflicts 43% Vietnam conflict 32% women 97% white	Semi-structured, face-to-face, individual interviews	Constant comparison method

EXPERIENCES OF ACCESSING SERVICES

Quantitative Studies

To summarise the information from quantitative studies, data has been split into the following sections: 'Causes', 'Symptom attribution', 'Timeline', 'Consequences' and 'Controllability' based upon the health models (HBM and SRM). The studies included: Spoont et al., (2005), Currier et al., (2013), Harik et al., (2016), Possemato et al., (2018) and Hardy et al., (2020). Table 4 illustrates the key relevant findings from these studies. Harik et al., (2016) assessed PTSD knowledge in veterans and non-veterans e.g. emergency workers (50:50 split). Therefore, the data reported is based on the whole sample as reported, but veteran-specific information is highlighted where possible.

Causes

Three studies investigated beliefs about the cause of PTSD (Spoont et al., 2005; Currier et al., 2013; Harik et al., 2016), although this was conducted in different approaches. Spoont et al., (2005) compared biological and psychological causes. The majority of participants strongly disagreed with all biological statements (germs, exposure to chemicals, chemical imbalance and hereditary). Regarding psychological causes for experiencing PTSD, 'Things I did in the past' received the highest strength of agreement (64% strongly agree), followed by 'Being punished' (60% strongly agree; 18% agree) and 'Never pulled it together like I should have' (52% strongly agree; 20% agree).

Currier et al., (2013) divided the cognitive processing of trauma (CPOTS) into adaptive processing (positive cognitive restructuring, resolution/acceptance and downward comparison), and maladaptive processing (denial and regret). They found that combat exposure, maladaptive processing and general trauma exposure were the best predictors of posttraumatic stress (PTS). Maladaptive processes included stigmatising beliefs such as '*I*

blame myself for what happened'. Participants internalising the traumatic events they have experienced and placing the blame upon them, led to greater PTS.

Harik et al., (2016) reported that the majority of participants identified true PTSD criterion events, scoring an average of 84.2% (e.g. combat 91.7%, car accident 90.4%, observing someone get killed 90%). However, participants also reported distractor items as true causes of PTSD (e.g. divorce 51.8%, getting fired from a job 49.2%, learning your spouse had an affair 46.5%). Harik et al., (2016) reported that veteran status significantly predicted trauma recognition, where veterans (M = 74.7%; SD = 15.8%) had significantly higher scores than non-veterans (M = 70.0%, SD = 16.5%).

Symptom Attribution

Using the DSM-5 criteria for scoring, participants were deemed to accurately attribute 62.3% of items as a symptom of PTSD (Harik et al., 2016). Participants were more accurate at correctly identifying true symptoms of PTSD, as measured by the DSM-5 (APA, 2013: nightmares about the trauma 93%, feeling very upset when reminded of the trauma 92.7%, avoiding places or people that remind you of the trauma 90%) than recognise false or distractor items (alcohol or drug addiction 85.7%, decreased appetite 78.4%, feeling hyper or excited for several days straight 72.2%). Veteran status was not a significant predictor of symptom recognition; however help-seeking participants were significantly more accurate than non-help-seeking participants.

On average, serving personnel in Hardy et al., (2020) attributed posttraumatic symptoms more strongly to their TBI (M=2.15, SD=1.16). Lack of sleep was the second most common attribution for their symptoms (M=2.02, SD=1.37), followed by PTSD (M=1.79, SD=1.51), then pain (M=1.79, SD=1.32), depression (M=1.38, SD=1.41), readjustment stress (M=1.35, SD=1.43) and finally deployment stress (M=1.14, SD=1.15). However, it was noted that

individuals with a formal diagnosis of PTSD or those who reported more severe affective symptoms were more likely to attribute their posttraumatic symptoms to PTSD than TBI alone, once other contributing factors had been controlled for. Participants were more likely to attribute their PTS symptoms to both TBI and PTSD if they experienced a higher burden of symptoms across the four categories.

Timeline

The only study which explored beliefs about PTSD duration was Spoont et al., (2005). 96% of participants stated they believed they would permanently experience PTSD symptoms and 4% thought it would last a long time, but eventually will disappear. This suggests that most veterans do not believe that PTSD is treatable. This will inevitably have an impact on their help-seeking behaviour.

Consequences

Two studies reported participants' beliefs about the consequences of experiencing PTSD (Spoont et al., 2005; Possemato et al., 2018). Spoont et al., (2005) asked participants to state whether PTSD had impacted their life positively or negatively in ten areas. These included ability to work, how they see themselves, spiritual or religious beliefs or practices, ability to take care of themselves and others whom they are responsible, worldviews, ability to understand others' problems, relationships with others, physical health and hopes and dreams for their life. Participants believed that PTSD had a negative consequence on most areas of their life. Most strongly supported was 'physical health' and 'hopes and dreams for my life', both with 78% of participants rating PTSD had a negative impact, followed by 'relationships with other people' (73%) and 'the way I see myself' (71%). Few participants did believe that were certain positive consequences to experiencing PTSD, with 'ability to understand other people's problems' rated positive by 32%, followed by 'spiritual or

religious beliefs and practices' (24%). However in both cases, a higher number of participants reported a negative impact on these areas (52% and 39% respectively).

Veterans perceived PTSD to harm their career (7.4% of participants), mean others would like them less (29.6%), they would be seen as weak (18.5%), were concerned about attracting a label (40.7%) and seeking treatment would mean they felt inadequate (3.7%). Veterans also said they avoided places or things that remind them of the trauma (51.9%, Possemato et al., 2018).

Controllability

Data on beliefs about controllability of PTSD symptoms suggests a divide in perception. Spoont et al., (2005) reported that 21% participants perceived no control over their symptoms, 30% a little control, 28% some control, 9% a lot of control, and only 2.5% believed they had complete control of their PTSD symptomology.

Table 4

Summary of relevant findings from quantitative studies

Study	Findings
Currier et al., 2013	Cognitive Processing of Trauma Scale: • Maladaptive processing: reluctance to talk, PTS, depression to <.001 and emotional reactions at <.01 • Adaptive processing: emotional reactions and PTS at <.001 (negatively). Depression at <.01 and reluctance to talk (negatively) and PTG at <.05 Posttraumatic stress (PTS) had significant relationship with: general trauma exposure, combat exposure, maladaptive cognitive processing, adaptive cognitive processing (-), reluctance to talk at <.001, and emotional reactions at <.01 Predictors of PTS: combat exposure and maladaptive processing at <.01 and General trauma exposure at <.05 and adaptive processing inversely at <.001
Hardy et al., 2020	On average, participants attributed their posttraumatic symptoms more strongly to TBI (mean=2.15, SD=1.16) than to any other category, with most attributing their symptoms at least moderately to TBI. Other attribution categories: • Lack of sleep was the second highest category (mean=2.02, SD=1.37) • PTSD (mean=1.79, SD=1.51) • Pain (mean=1.79, SD=1.32) • Depression (mean=1.38, SD=1.41) • Readjustment stress (mean=1.35, SD=1.43) • Deployment stress (mean=1.14, SD=1.15) More severe affective symptoms were associated with decreased odds of TBI attribution (odds ratio=0.90, 95% CI=0.83–0.97) and increased odds of PTSD attribution (odds ratio=1.14, 95% CI=1.03–1.26). A PTSD diagnosis was highly associated with PTSD attribution (odds ratio=2.44, 95% CI=1.07–5.58). A higher burden of symptoms across all categories (cognitive, affective, somatosensory, and vestibular) was associated with a higher likelihood of attributing symptoms to both TBI and PTSD.

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Study	Findings
Harik et al., 2016	Recognition of Cause of PTSD: participants had an average score of 72.2% (8.7/12 items). Participants were often able to correctly identify true criterion A traumatic events (Mtrue items = 84.2%). They were less able to correctly identify distractor items as false (Mfalse items = 58.6%). Recognition of symptoms (as detailed by DSM-5): participants on average answered 62.3% (8.7/14) of items correctly. Participants were able to correctly identify true symptoms (Mtrue items = 89.1%), but performed poorly on false items (Mfalse items = 31.0%), often believing that distractor symptoms (e.g., decreased appetite, drug addiction) were PTSD symptoms. Controlling for demographic and clinical covariates, veteran status significantly predicted trauma recognition: veterans (M = 74.7%; SD = 15.8%) had significantly higher scores than nonveterans (M = 70.0%, SD = 16.5%). PTSD help-seeking (M = 67.8%, SD = 13.5%) had significantly better symptom recognition than non-help-seeking participants (M = 61.3%, SD = 11.6%).
Possemato et al., 2018	Perceived Stigma and Barriers to Care (percent theme was endorsed): • I don't trust mental health professionals = 37.0% • I am concerned about being labelled with a mental health problem = 40.7% • It would harm my career = 7.4% • I don't go places or do things that remind me of past traumas = 51.9% • Talking about my problems is too difficult for me = 40.7% • I think talking about my problems will make them worse = 29.6% • Mental health care does not work = 22.2% • People would like me less if they knew I was receiving help for a mental health problem = 29.6% • I would hide from others that I have seen a mental health provider = 22.2% • It would be too embarrassing = 18.5% • I would be seen as weak = 18.5% • I would feel inadequate if I received mental health treatment = 3.7% • I don't know where to get help = 22.2% • Mental health care costs too much money = 18.5% • I don't have the time to attend treatment = 14.8% • I don't have adequate transportation = 7.4% • I would have difficulty getting time off from work = 7.4%

EXPERIENCES OF ACCESSING SERVICES

Study	Findings
Spoont et al., (2005)	Cause: All participants attributed some psychosocial causation, and 56% endorsed only psychosocial causation. A belief in some biological causation was held by 36%. Duration of PTSD symptoms: 96% permanent; 4% long time but eventually will go away. Consequences: Every aspect was rated as negatively impacted by the majority. Most strongly supported was physical health (78%) and hopes and dreams for my life (78%). A small percentage experienced positive effects of PTSD (empathy). Controllability: No control 21%, A little control 30%, Some control 38%, A lot of control 9%, Complete control 2.5%. Perceived controllability and psychosocial explanatory model were significantly correlated ($r = 0.34$; $p = 0.002$; $N = 79$); all other subscales were statistically independent.

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Qualitative Studies

To summarise the data from qualitative studies, themes relevant to the research question are grouped below. The studies included in the qualitative analysis were Spoont et al., (2009), Haun et al., (2016), Price et al., (2016), Sherman et al., (2016), Hayes et al., (2017), McGaw et al., (2018), Possemato et al., (2018). Table 5 illustrates the relevant themes identified in these studies. Broad topics and themes documented from these studies include: 'PTSD label', 'Symptom attribution', 'Influences on conceptualisation', 'Consequences' and 'Timeline'.

PTSD label

Veterans experienced similar conceptual debates in defining PTSD as an illness or whether post-trauma suffering is part of normal life. They also were uncertain how to know if they had a problem, what classifies as a clinically significant trauma and what the threshold is for a diagnosis or treatment (Spoont et al., 2009).

Receiving a diagnostic label of PTSD was met with split oppositional responses; validation or uncertainty (Spoont et al., 2009). Some veterans felt receiving the diagnosis provided meaning to their difficulties and validated their experiences. However, others felt a lack of clarity about the applicability of PTSD label caused uncertainty about whether they should seek treatment or not, and contributed to denial. Spoont et al., (2009) concluded that veterans continued to be unclear as to whether they had PTSD or not.

PTSD has also been characterised as an umbrella term by veterans (McGaw et al., 2018). Participants felt their experiences were so pervasive and ingrained into all aspects of their life. A diagnosis of PTSD also left participants with apprehension about living with the label (Hayes et al., 2017).

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'Symptom' attribution

Five studies identified themes relating to participants' beliefs about PTSD symptoms (Spoont et al., 2009; Haun et al., 2016; Sherman et al., (2016); McGaw et al., 2018; Possemato et al., 2018). Re-experiencing of symptoms was central to veterans aligning their experiences with a PTSD label (Spoont et al., 2009). Re-experiencing occurred via reminders, nightmares and flashbacks (Haun et al., 2016; Possemato et al., 2018). Night terrors, sleep disturbance and insomnia were described by participants (Haun et al., 2016; Possemato et al., (2018). Conversely, Sherman et al., (2016) noted that participants did not discuss challenges related to re-experiencing symptoms, such as flashbacks or nightmares. These experiences are felt internally and therefore because this study focused on a relational context (e.g. parenting); participants may not have shared experiences of this. Participants identified avoidance of trauma-related reminders, negative impact on cognition and mood, and alterations in arousal, which mirror three of the four DSM-5 categories for PTSD. Avoidance of people and places was also a sub-theme for Possemato et al., (2018) under their theme 'symptoms of PTSD'.

Hyper-vigilance was evident within several studies as a symptom of PTSD (Haun et al., 2016; McGaw et al., 2018; Possemato et al., 2018). This was explored as 'jumpiness' and 'always being on guard' (Possemato et al., 2018), becoming overwhelmed with large number of people (Haun et al., 2016; McGaw et al., 2018*).* Participants expressed acute fear associated with their traumatic experiences when in crowded places and as a response to certain noises such as the sound of planes or popping (Haun et al., 2016; Sherman et al., 2016). These experiences were linked with participants' flashbacks.

Duration, severity and disability of distress sensations were used to attribute participants experiences of PTSD (Spoont et al., 2009), which is consistent with a medical

model of PTSD. Temporal onset of symptoms was a main factor facilitating participants to match their symptoms with PTSD (Spoont et al., 2009). However, this led to the inclusion of symptoms/behaviours not found in the medical model of PTSD e.g. sadness, depression, alcohol misuse, risk-taking, divorce, difficulty to hold a job and chronic fatigue. Participants attributed all post-trauma adjustment difficulties into their PTSD model (Spoont et al., 2009).

Four studies found emotional experiences to be incorporated into participant's model of PTSD (Haun et al., 2016; Hayes et al., 2017; Price et al., 2016; Sherman et al., 2016; Possemato et al., 2018). All five studies identified anger, aggression and irritability. A sense of feeling numb was also identified with participants (Haun et al., 2016; Price et al., 2016; Sherman et al., 2016), as was depression and anxiety (Haun et al., 2016; Hayes et al., 2017; Possemato et al., 2018).

Influences on conceptualisation

Throughout the studies included, there were several factors which appeared to influence participant's conceptualisations and beliefs about PTSD, such as the social influence of others, stigma and the media (Hayes et al., 2017; Possemato et al., 2018; Spoont et al., 2009).

Some veterans only considered the PTSD label to reflect their experiences once they were provided with this by a medical profession or spouse who had researched it (Spoont et al., 2009). Additionally, veterans engaged in social comparison and identification with other veterans to attribute their experiences of distress.

The media was also noted to impact beliefs about PTSD in two studies (Hayes et al., 2017; Spoont et al., 2009). The extreme and stereotyped portrayals have integrated into lay

models of PTSD (Spoont et al., 2009). A quote reported in Hayes et al., (2017) depicts this view of PTSD with anger and the influence of media:

"I am worried that they're going to be scared because they don't really understand it. Maybe they heard about somebody that had it or maybe they watched a movie and somebody flipped out".

Veterans also voiced concerns about judgement and social rejection due to stigma with a label such as PTSD (Hayes et al., 2017; Spoont et al, 2009). An example extract from Possemato et al., (2018) demonstrates this:

"When somebody who goes out and does something absolutely totally terrible and then somebody in his family says, well . . . he had PTSD. Well guess what, now the seven of us sitting in this room, are all a bunch of domestic terrorists. And so it's not a fair label to anybody".

This has led to self-stigmatising beliefs that is not acceptable to seek support because they should be able to cope without professional care (Possemato et al., 2018) and therefore view PTSD as a weakness they should not experience. McGaw et al., (2018) reported that individuals with PTSD experience an inability to cope. In the context of this study, it was an inability to cope with the stresses of being a new parent and feeling an inappropriate role model for their children. This highlights the perception of PTSD being a negative weakness and a failing.

Consequences

Participants attributed their experiences of PTSD to have impacted all aspects of life, either directly or indirectly. Areas discussed included employment/occupation (Haun et al., 2016; Hayes et al., 2017; Possemato et al., 2018), relationships through disconnectedness,

intimacy and trust (Haun et al., 2016; Hayes et al., 2017; McGaw et al., 2018; Price et al., 2016; Sherman et al., 2016), the use of alcohol to cope (Haun et al., 2016; Hayes et al., 2017; Possemato et al., 2018), self-esteem (Price et al., 2016); functional tasks due to memory and concentration (Haun et al., 2016) and contact with law enforcement (Hayes et al., 2017). These themes mirror the consequences attributed to PTSD that were reported by the quantitative studies.

Timeline

Veterans expressed beliefs that PTSD is not treatable or a valid treatment target (Possemato et al., 2018) and that treatment for PTSD is ineffective or even harmful. Therefore, veterans conceptualised PTSD to be an untreatable difficulty they had to always tolerate: "*You can't treat PTSD unless you erase our memories*" (Possemato et al., 2018). This matches the data reported in the quantitative study (Spoont et al., 2005). Additionally, participants noted they had not been 'cured' after undergoing PTSD treatment (Price et al., 2016).

Table 5

Summary of relevant primary and secondary themes from qualitative studies

Study	Primary Themes	Secondary Themes
Haun et al., 2016	Social participation	Relationship
		Employment
	Physical issues	Fatigue and sleep disturbance affecting function
		Night terrors left them fatigued and unable to concentrate
	Cognitive issues affecting function	Memory
		Concentration
	Emotional	Numbness
		Anger
		Road rage
		Fear
		Hypervigilance
		Depression and Anxiety
	Substance abuse issues	Substance abuse as a means to cope
Hayes et al., (2017)	Fallout from PTSD	Significance of the problem
		Apprehension
McGaw et al., (2018)	Disconnectedness	From family
		From role
		From community
	Transgenerational effects: “parented by someone with PTSD”	Inappropriate role modelling
	PTSD: an umbrella effect	

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Study	Primary Themes	Secondary Themes
Price et al., (2016)	Power/control	Powerless
		Efforts to control too much
	Esteem	Lack of self-esteem
		Self-blame
	Intimacy	Lack of intimacy
		Problems with sexual intimacy
		Problems in specific relationships
	Emotions/symptoms	Emotional numbing/lack of positive affect
		Experience of general negative affect
		Experience of guilt
		Not feeling guilty
		Experience of fear
		Experience of anger
		Experience of sadness
		Reference to alcohol/drug use
	Education/work	Negative references to education/work
		Military life
	Positive effects of therapy	Not “cured”/expect to continue to improve
Possemato et al., (2018)	Symptoms of PTSD	Anger, aggression, and irritability
		Re-experiencing via reminders, nightmares, and flashbacks
		Avoidance of people, places
		Jumpiness/always being on guard
		Insomnia
	Functional concerns	Unemployment
		Transitioning out of the military
	Other behavioural health concerns	Alcohol/substance misuse
		Depression/suicidality
Spoont et al., (2009)	From Sensations to Symptoms	
	From Symptoms to an Illness Label	
	Participants’ Descriptions of Their Problems	

Quality

There was variety in the quality scores of the studies, with an average score of 31.2, and a range of 28 (66.7%) to 39 (92.9%). Table 6 documents the quality scores for all 11 studies included. Low scoring elements included 'evidence of sample size considered in terms of analysis' and 'evidence of user involvement in design'. No quantitative study explicitly discussed a sample size requirement for statistical power, and qualitative studies varied with regards to reaching saturation. If saturation was discussed, it was often in the discussion when considering strengths and weaknesses of the study; few studies appear to have set a sample size from the outset. One study made reference to an author being an Army veteran (Hayes et al., 2017). There was also a lack of information on recruitment data as it was felt certain studies did not provide a detailed description to enable replication. Most studies discussed general frameworks or constructs regarding their study, however few explicitly defined PTSD. Harik et al., (2016) explicitly used DSM-5 to define PTSD, but this imposes a medical understanding. This may reflect the diverse aims of the studies included; PTSD beliefs were considered within the wider context. The 'statement of aims/objectives in main body of report' was strong throughout all studies.

Table 6

QATSDD scores

	Currier et al., 2013	Hardy et al., 2020	Harik et al., 2016	Haun et al., 2016	Hayes et al., 2017	McGaw et al., 2018
Explicit theoretical framework	3	3	3	2	3	3
Statement of aims/objectives in main body of report	3	3	3	3	3	3
Clear description of research setting	2	3	2	3	3	2
Evidence of sample size in terms of analysis	0	0	1	1	3	3
Representative sample of target group of reasonable size	2	2	2	3	2	3
Description of procedure for data collection	2	2	3	3	3	2
Rationale for choice of data collection tool(s)	1	2	2	3	3	2
Detailed recruitment data	2	1	2	1	2	3
Statistical assessment of reliability and validity of measurement tool(s) (Quantitative)	2	1	2	-	-	-
Fit between stated research question and method of data collection (Quantitative)	3	3	2	-	-	-

	Currier et al., 2013	Hardy et al., 2020	Harik et al., 2016	Haun et al., 2016	Hayes et al., 2017	McGaw et al., 2018
Fit between stated research question and format and content of data collection tool e.g. interview schedule (Qualitative)	-	-	-	3	3	3
Fit between research question and method of analysis	3	3	3	2	3	1
Good justification of analytic method selected	3	3	3	2	3	0
Assessment of reliability of analytic process (Qualitative)	-	-	-	3	3	3
Evidence of user involvement in design	0	0	0	0	3	0
Strengths and limitations critically discussed	2	2	1	2	2	2
Total:	**28**	**28**	**29**	**31**	**39**	**30**
Percentage:	**66.7%**	**66.7%**	**69%**	**73.8%**	**92.9%**	**71.4%**

Table 6

QATSDD scores - continued

	Possemato et al., 2018	Price et al., 2016	Sherman et al., 2016	Spoont et al., 2005	Spoont et al., 2009
Explicit theoretical framework	3	3	3	3	3
Statement of aims/objectives in main body of report	3	3	3	3	3
Clear description of research setting	3	2	3	3	3
Evidence of sample size in terms of analysis	0	0	0	0	2
Representative sample of target group of reasonable size	2	2	2	2	2
Description of procedure for data collection	2	2	2	3	3
Rationale for choice of data collection tool(s)	3	2	1	3	3
Detailed recruitment data	1	1	2	3	3
Statistical assessment of reliability and validity of measurement tool(s) (Quantitative)	2	-	1	2	-
Fit between stated research question and method of data collection (Quantitative)	3	-	2	3	-

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	Possemato et al., 2018	Price et al., 2016	Sherman et al., 2016	Spoont et al., 2005	Spoont et al., 2009
Fit between stated research question and format and content of data collection tool e.g. interview schedule (Qualitative)	2	3	2	-	2
Fit between research question and method of analysis	2	2	2	3	3
Good justification of analytic method selected	3	3	2	3	1
Assessment of reliability of analytic process (Qualitative)	3	2	3	-	2
Evidence of user involvement in design	0	0	0	0	0
Strengths and limitations critically discussed	2	3	2	3	2
Total:	**34**	**28**	**30**	**34**	**32**
Percentage:	**70.8%**	**66.7%**	**71.4%**	**81 %**	**76.2%**

Summary

There was general alignment between beliefs explored through quantitative and qualitative methods. However, there was variance in the conceptualisations of PTSD within the samples. Both medical and psycho-social models were endorsed by the qualitative and quantitative studies. Hyperarousal, avoidance of trauma-related reminders, negative impact on cognition and mood, and alterations in arousal were all reported, which mirror DSM-5 categories for PTSD. However, participants also included behaviours not found in the medical model of PTSD e.g. sadness, depression, alcohol misuse, risk-taking, divorce, difficulty to hold a job and chronic fatigue. Participants attributed all post-trauma adjustment difficulties into their PTSD model. Veterans believed PTSD to be incurable meaning they will permanently experience it, and did not feel they had much control over their experiences. This left them feeling a lack of control and power regarding their own mental health and low motivation to engage with services. Participants also reported PTSD caused negative consequences on several life domains such as occupation, relationships with others, view of themselves, physical health and stigma. PTSD as a label was discussed and there were divided beliefs about receiving this diagnosis. This was due to the debate of it being a medicalisation of human suffering or a clinical entity, which left uncertainty and apprehension within participants.

Regarding the sub-questions for this review, summaries are provided with caution and there were few studies to provide detailed answers. One study compared veteran status with non-veterans, where veterans had greater recognition about causes of trauma (Harik et al., 2016), suggesting that veteran populations have an increased chance of recognising causes of PTSD than other professions. One study explored posttraumatic beliefs in serving personnel (Hardy et al., 2020), and generally there was greater attribution of symptoms to TBI than psychological. Although a formal diagnosis of PTSD led to more attribution to PTSD, rather

than TBI alone. The studies included limited the ability to discuss cultural differences as all but one was conducted in the US, however there did not appear to be any difference between these. One study explicitly explored female beliefs (Haun et al., 2016), and reported that functional tasks were impacted by PTSD due to memory and concentration difficulties, which was not reported in other studies. Spoont et al. (2009) stated that there were no differences between accounts of veterans in relation to their war era (sub-question four). The authors postulated that this was due to the commonality of shared experiences.

Discussion

This review aimed to explore how serving personnel and veterans conceptualise PTSD and their beliefs about it. From 11 studies included in the review, serving personnel and veterans conceptualised symptoms within both a medical model of PTSD and additional psycho-social contexts. The findings of this review align with the key elements of the SRM (Leventhal and Coleman, 1997; Leventhal et al., 1999): label, symptoms, cause, perceived controllability, perceived course, and consequences on their life, such as relationships and employment.

The symptoms of PTSD as categorised by the DSM-5 were evident within the literature: re-experiencing, avoidance, negative mood and cognition and hyperarousal (APA, 2013). However, this was variable across studies e.g. not all noted re-experiencing. Additional experiences not mentioned in the DSM-5 were also incorporated into their models of PTSD (Harik et al., 2016; Spoont et al., 2009). This is consistent with previous literature noting that lay models of health and illness may vary (Hughner & Kleine, 2008). Furthermore, veterans debated the concept of a PTSD diagnosis as validating a medical illness or medicalising human experiences following a traumatic experience, which reflects the views of some professionals in previous literature (Breslau, 2004).

Veterans with a diagnosis of PTSD often do not seek mental health support as they do not believing they have a mental health difficulty requiring support (Fikretoglu, Guay, Pedlar, & Brunet, 2008; Hoge, Auchterlonie, & Milliken, 2006). Therefore, having a semantic knowledge of PTSD might not be adequate for some veterans to attribute their experiences to PTSD and conceptualise the clinical significance of this. Furthermore, anticipation of public stigma was identified within the review to influence beliefs about PTSD as it is in contrast to their internalised military values (Schuy et al., 2019). There has been a wealth of literature documenting the impact of stigma beliefs on mental health and a barrier to help-seeking (Coleman et al., 2017; Mellotte, Murphy, Rafferty & Greenberg, 2017).

Participants referred to several influences on their PTSD models, such as social comparison and may normalise their experiences meaning they do not assign the label of PTSD (Biddle, Donovan, Sharp, & Gunnell, 2007). Normalising beliefs has been found to play a major role in the lack of seeking professional help for mental health difficulties (Seigel, Dors, Brants, Schuy, & Rau, 2018).

Limitation of the studies

Quantitative studies used self-report questionnaires and therefore the responses may have been influenced by social desirability. This may have also been enacted as purposive sampling and self-selection offers bias in the sample. Throughout, tools were often described in detail with a measure of validity; however, few quantitative studies explicitly provided a rationale for the use of these tools. This meant that their relevance to the study aims and research questions had to be inferred, rather than explicitly detailed. Therefore, there is limited information on the quality of the evidence based upon the measures used. A thorough explanation of the rationale and relevance to the research questions, validity and reliability of measures would have allowed for greater interpretation of the results. Some quantitative

studies provided comments for participants to judge or primary codes (Harik et al., 2016; Possemato et al., 2018). This may have led to pre-existing ideas of what researchers expected to find. Deductive approaches may miss important themes, and is different to the thematic or phenomenological approaches used by other studies, which allows for inductive analysis and themes to emerge. However, the qualitative data appears to mirror the quantitative data and the semi-structured approach used in studies would have allowed for both expected and unexpected themes to emerge.

It is important to note as the majority of studies did not have an expert by experience as part of the research process; only one mentioned this. Therefore, the development and implementation may have been representative of the previous research base, not the individual participants' experiences. This may be true for the measures and pre-set questions/deductive methods chosen to explore the research question. Many studies used the same questionnaires, likely because they were the most established. However, this is integral to research on beliefs, as researchers may have chosen certain questions or questionnaires in response to their own beliefs about the topic, therefore steering the focus of the research. Including an EBE (client or family/carer) in development of research aims, ethical issues, recruitment, theoretical framework, data analysis and dissemination may avoid a biased focus on methods, approaches and materials used. Furthermore, this is why including the rationale for measures and questions helps the transparency of decisions made. EBE's may also provide meaningful insights that will add to the research and engage participants better.

Within the qualitative designs, there were a variety of approaches used to explore how participants conceptualise PTSD. The different theoretical underpinnings between these approaches were noted and must be considered when reporting this data.

Limitations of review

Inclusion specified published articles only therefore unpublished and grey literature is not included and represented. Additionally, only four databases were searched meaning there may be other studies not identified. Participants within the included studies were often white, male, Army veterans, thus having implications for generalising to other populations. The context in which the studies were conducted, and the emphasis on exploring PTSD beliefs varied, therefore making it hard to directly compare. However, this was overcome using the health models as frameworks and the use of the QATSDD. Ten percent of articles were independently reviewed using the search terms at each stage (title and abstract and full-text) for inter-rater reliability. However, the quality scores on the QATDSS were completed by the lead researcher only and therefore reflect one person's judgement.

Ten of the 11 studies were conducted in US (one in Australia) and therefore, it is hard to generalise to other countries as PTSD may be culturally sensitive and reflect the context of that country (Bercken, 2001; Young, 1995). Therefore, it would be important for research to be conducted exploring the meaning of PTSD and the conceptualisations of this in other countries. Co-morbidity is high for veterans with PTSD (Murphy et al., 2019), therefore it is noted that this review did not account for the influence that this may have on participants' conceptualisations of PTSD. Additionally the majority of the studies were cross-sectional and therefore reflect beliefs at a particular time. Research exploring beliefs in a longitudinal approach would add key knowledge to this literature as beliefs may change over time. An awareness of what causes changes to PTSD beliefs and conceptualisations would also add important information to aid help-seeking. It is also acknowledged that including both qualitative and quantitative studies can be conceptually hard due to methodological diversity. Therefore guidance on conducting a narrative review and including diverse methods was followed (Popay et al., 2006; Sandelowski, Voils & Barroso, 2006). This is also why the QATSDD was chosen for quality assessment (Sirriyeh et al., 2011). Due to the diversity of

the methodological approaches used, the qualitative and quantitative data was presented separately, with themes across both commented upon throughout and then triangulated in the summary and discussion. Although this allowed for greater synthesis within each quantitative and qualitative section to ensure data was not diluted, it is acknowledged that segregating the two methodologies may be seen as a limitation of the review.

Clinical implications

PTS experiences are measured in various military-related research studies and there are estimates of between 6.2% and 30% of military personnel and veterans experiencing PTSD (Stevelink et al., 2018; VA Department of Veterans Affairs, 2018). However, as demonstrated in this review, individuals can conceptualise this label differently and have varying beliefs about it. Therefore, the subjective beliefs and experiences of veteran and serving personnel should be taken into account by clinicians, in line with the HBM (Rosenstock, 1966) which focuses on the beliefs and attitudes of individuals. Clinicians should ensure that they ask their client what PTSD means for them, their beliefs about PTSD and how they have come to conceptualise it. Serving and veteran populations internalise media representations, experiences of comrades and public stigma, meaning their beliefs may not align with DSM-5 criteria and they may be reserved in accepting the label. Consequently, without exploring these factors, they may disengage from services (Coleman et al., 2017).

Various aspects of the PTSD models could be linked with lack of help-seeking, such as stigma (Coleman et al., 2017), and knowledge and awareness of causes and symptoms. Therefore, topics discussed within this review should be considered when decisions about engagement with military personnel and veterans who experience PTSD are undertaken. Participants misrepresented symptoms to be incorporated into their model of PTSD which are

not classified as symptoms in the DSM-5. Therefore, increasing symptom awareness for military and veteran populations may lead to better recognition.

Conclusion

This review exploring PTSD beliefs and attributions included predominantly US-based studies, with varying quality**.** Therefore, additional research expanded the limitations of these studies would strengthen the literature. Beliefs about PTSD, with both medical and psycho-social models endorsed. It is vital to explore underlying beliefs about PTSD and how PTSD is conceptualised with those who are experiencing it, to support ongoing work to reduce barriers to access mental health care. Beliefs about PTSD may be modified within military and veteran populations, and therefore are well placed to be central in a targeted approach to reduce barriers and anticipated stigma.

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Chapter Two: Empirical paper

Exploring how veterans with mental health difficulties, alcohol use and traumatic brain injury, experience accessing mental health services

Abstract

This study explored the lived experiences of six male UK veterans with mental health difficulties (predominantly PTSD), alcohol misuse and traumatic brain injury (TBI), accessing mental health services in England. An Interpretative Phenomenological Analysis (IPA) framework was used to explore barriers and facilitators to help-seeking, and veterans' conceptualisation of their difficulties. Purposive sampling recruited veterans from a veteran-specific mental health service within the North-West of England. Face-to-face semi-structured interviews identified four super-ordinate themes emerged reflecting their journey to help-seeking: 'Denial to acceptance of needing support', 'Sense of self', 'Knowledge is power' and 'Relationship with services'. Each theme had between two and four sub-ordinate constituents within them. Themes were viewed as barriers and facilitators to accessing mental health services, which aligns with previous research exploring help-seeking with mental health experiences. Many of the barriers to accessing services that were evident a decade ago were still present; therefore ongoing programmes to facilitate engagement are required to continue to reduce barriers. The importance of both promoting access to services and engagement with services was highlighted. This research can be used by clinicians to facilitate an understanding of the journey veterans have experienced and themes which are important to them.

Key words: Veteran, PTSD, alcohol misuse, TBI, help-seeking

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Introduction

The United Kingdom (UK) government classifies a veteran as anyone who has served at least one day and/or had one day paid work with the military. Veterans have a greater prevalence of mental health difficulties than the general population and a higher prevalence of Post-Traumatic Stress Disorder (PTSD) than serving personnel (Stevelink et al., 2018). Despite the prevalence of mental health difficulties, it is estimated that 60-80% of Armed Forces personnel with a mental health difficulty do not seek help (Hines, Gribble, Wessely, Dandeker, & Fear, 2014; Sharp et al., 2015). However, within a help-seeking veteran population, PTSD is the most reported mental health difficulty (82%), followed by anger difficulties (74%), common mental health disorders (CMDs: 72%) and alcohol misuse (43%: Murphy, Ashwick, Palmer, & Busuttil, 2019).

Alcohol consumption is more common in the UK Armed Forces than in the general population (Fear et al., 2007), and 61% of veterans are at an increased risk of alcohol-related harm (Ministry of Defence [MOD], 2017). However, recognition for alcohol misuse is lower than for CMDs and PTSD (Stevelink et al., 2019), and poorer treatment outcomes are noted for co-morbid CMDs and alcohol misuse (Goodwin et al., 2015). Co-morbidity is high, with comorbid alcohol use in those with PTSD ranging between 9.8% and 61.3% (Debell et al., 2014) and with 32% of veterans meeting criteria for PTSD also meeting criteria for three additional health outcomes (Murphy et al., 2019). This illustrates the complex nature of presentations within help-seeking veterans, which may contribute to the poorer treatment outcomes compared to the general population (Murphy et al., 2019), thus warranting further exploration.

Veterans also have a higher prevalence of traumatic brain injury (TBI) compared to civilians and are more likely to experience mental health co-morbidities with a TBI (King et al., 2012). A TBI is defined as

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"*a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness*" (Dawodu, 2019).

McHugo et al. (2017) reported that 80% of civilian individuals at a mental health service in US, who experienced co-morbid mental health and substance use disorder, also screened positive for at least one traumatic brain injury (TBI). This presentation was more common among individuals with PTSD (McHugo et al., 2017), thus having important implications for veteran populations who are at increased risk of developing mental health difficulties due to exposure to traumatic events (Vogt, Fox, & Leone, 2014). TBI has been coined a 'signature wound' of the recent Afghanistan and Iraq wars in America (Snell & Halter, 2010), and the combination of mental health difficulties and TBI had been found to be the strongest predictor of functional outcome and disability in veterans (Lippa et al., 2015). Therefore, it is important to explore these factors impacting veterans' help-seeking and increase awareness of their experiences.

It is noted that various symptoms of TBI and PTSD overlap, such as sleep disruption, irritability, mood lability and post-traumatic memories (Snell & Halter, 2010). However, veterans with a mild TBI (mTBI) and co-morbid mental health difficulties attribute symptoms and functional deficits more to TBI than psychological causes (King, Beehler, Vest, Donnelly, & Wray, 2018). Rather than using depressive terminology, Armed Forces personnel with mental health difficulties and deployment-related TBI express emotional distress through somatic experiences, such as anger, stress, interpersonal difficulties or loss of control, in line with the 'warrior culture' in the military (Cole et al., 2019). Therefore, it is important to explore lay models and beliefs about difficulties, which may vary due to several

contextual factors (Hughner & Kleine, 2008). There may be additional barriers or facilitators related to this population who experience a complex multi-morbidity.

Many veterans delay seeking formal help for many years after leaving service (MacManus & Wesseley, 2013), and often present to services at the point of crisis (Fraser, 2017). Of those with a mental health difficulty, although the majority sought informal support, around half accessed non-medical support and medical support (Stevelink et al., 2019). Veterans were significantly less likely than serving personnel to speak to their social network and non-medical professionals, but more likely to visit their GP than serving personnel. Therefore, personnel who had been operationally deployed were less likely to access support, despite PTSD and alcohol misuse being more prevalent within deployed personnel (Stevelink et al., 2018).

Qualitative research has explored these barriers to help-seeking in veterans (Bovin et al., 2019; Kim, Britt, Klocko, Riviere, & Adler, 2011). Mellotte, Murphy, Rafferty and Greenberg (2017) added to previous accounts by identifying two distinct stages of help-seeking, with specific barriers and facilitators at each stage: initial help-seeking and pathways through treatment. Initial barriers incorporated recognition of the problem, self-stigma and anticipated public stigma, while facilitators included being in crisis, support from their social network, motivation and the media. Barriers through treatment comprised practical barriers and negative beliefs about services; however facilitators included having a diagnosis, accessing a veteran-specific service and developing a positive therapeutic relationship (Mellotte et al., 2017). Similar themes for facilitators were found when exploring positive pathways for active service personnel, with the addition of overcoming stigma (Murphy, Hunt, Luzon, & Greenberg, 2014). Stigma has been documented to be central to veterans' help-seeking journey, with five overarching themes highlighted including: non-disclosure, individual beliefs regarding mental health, anticipated and personal experiences of stigma,

career concerns and factors influencing stigma (Coleman, Stevelink, Hatch, Denny, & Greenberg, 2017). This highlights many of the barriers and facilitators veterans experience when help-seeking.

Upon leaving the military, support often falls to the National Health Service (NHS). Nevertheless, veterans' reticence to seek help for mental health difficulties is compounded by mainstream NHS services being ill-equipped to recognise and respond to veterans' mental health needs (MacManus & Wessely, 2013). However, veterans are more likely to engage with veteran-specific services, especially if difficulties are related to their military experience (Fraser, 2017). This has important implications as individuals who present to services earlier generally recover quicker and require fewer resources. The 'Strategy for Our Veterans' (HM Government, 2018) set out their vision and principles for the UK in supporting veterans, in addition to the Armed Forces Covenant which states military personnel and their families must be treated fairly (MoD, 2019). This strategy documents five cross-cutting factors that provide a backdrop to veteran's service provision (public sector, charities and private sector) and six interconnected themes that affect veterans' lives that should be considered to promote best practice by 2028.

Rationale:

Previous literature has highlighted the growing prevalence of the multi-morbidity of mental health, alcohol misuse and TBI in veterans, paired with a reluctance to seek support in those with these morbidities. Research has also emphasised barriers and facilitators to accessing services for mental health difficulties within veterans, but this has not been explored with veterans experiencing all three difficulties explored in this paper (mental health, alcohol misuse and TBI). Furthermore, previous literature stated that veterans align their difficulties more with biological rather than psychological causes when experiencing

mental health difficulties and TBI. Therefore, it is worth exploring if the presence of a TBI elicits additional barriers or facilitators to accessing support and increase help-seeking literature.

Aims:

The overarching aim of this study was to explore the lived experience of veterans accessing mental health services with mental health difficulties, a TBI acquired during service and hazardous/harmful alcohol use. Additional sub-aims included 1) to explore the journey of help-seeking, 2) to explore facilitators and barriers to accessing support and 3) to explore attributions of symptoms and how these may have impacted on veterans' experiences of accessing mental health services.

Method

Participants

Participant demographic characteristics

A purposive sampling strategy was used (Morse, 2007) to recruit six male participants who reported a diagnosis of PTSD, alcohol misuse and TBI. All had been operationally deployed during their service. Table 1 details additional participant demographics. The parameters being stringent for inclusion meant that the homogenous requirements for IPA were met (Smith, Flowers, & Larkin, 2009). Recruitment continued until saturation was reached, however a sample of between four and ten is recommended for a professional doctorate (Smith, Flowers, & Larkin, 2009).

Table 1
Detailed Participant Demographic Characteristics

	Age at interview	Military	Time served (years)	Reason for leaving	Time since left (years)	How acquired brain injury	Where they are in their help-seeking journey
Dave	61-65	Army	16-20	Decided to leave	26-30	Car crash and boxing in military	End
John	46-50	Army	16-20	Medically discharged	6-10	Fighting	During
Luke	46-50	Army	21+	End of service time	1-5	Fell down a set of stairs during deployment	End
Matt	31-35	Army	11-15	Decided to leave	1-5	Car crash on leave	During
Jack	31-35	Army	6-10	Medically discharged	1-5	Explosion during deployment	Start
Peter	51-55	Royal Air Force	20	Decided to leave	16-20	Explosion during deployment	Start

Study Setting

Participants were recruited from an NHS specialist military veteran's mental health service in the North-West of England, United Kingdom. Although one service was used, it

was the main service for veteran mental health and covered a large geographical area (whole of the North-West). This is an outpatient service, which provides evidence-based psychological interventions to ex-service personnel for conditions such as depression, PTSD and alcohol and substance misuse. To maintain anonymity, this service is referred to as the NW service and participants have been assigned pseudonyms.

This study explored access to mental health services in general, therefore, despite using one NHS recruitment site (NW), individuals were asked about their journey in its entirety and all participants spoke about several services. This encompassed their experiences of help-seeking with any service or support they had accessed, or tried to access, since leaving the military, e.g. non-veteran specific NHS services and charities.

Table 2
Inclusion and Exclusion Criteria

Inclusion Criteria	• A veteran according to the UK definition • Self-report a TBI acquired during their military enlistment • Had consumed alcohol to hazardous (8+) or harmful (16+) levels (determined by the AUDIT) • Experiencing mental health difficulties e.g. PTSD • Have good comprehension of English language for the purpose of the interview • Have capacity to consent
Exclusion Criteria	• A score of 2+ on the Patient Health Questionnaire (PHQ-9) question nine (regarding suicidality) to minimise the risk to self and those experiencing extreme distress • If a health professional deemed their participation clinically inappropriate e.g. taking part may cause extreme distress or negatively impact their therapy

Data Collection

Recruitment was carried out between August 2019 and February 2020. Throughout recruitment, ten participants agreed to be contacted, however, prior to interviewing, four changed their mind, citing a change in circumstances e.g. housing. The author met with clinicians at the NW service to explain the inclusion/exclusion criteria (Table 2). Clinicians

assessed eligibility at the NW service and informed their clients about the study. Additional veterans who were on the NW service database who met criteria and had agreed to take part in research (asked at their initial assessment for the service), were contacted by clinicians at the NE service. If the inclusion criteria were met by prospective participants and they wished to participate, clinicians provided the participant information sheet (Appendix C). With consent, clinicians then provided the researcher with the participant's contact details. The researcher spoke with participants at least 24 hours later to answer any questions and arrange an interview. The NW service also posted an advert on their social media account; however, this did not result in any recruitment. Interviews were conducted at places used by the service, e.g. General Practitioner (G.P.) practices, day centres, and fire stations.

The Patient Health Questionnaire (PHQ-9) and Alcohol Use Disorders Identity Test (AUDIT) were completed as routine practice within the service. These scores were only used to assess eligibility for the study (Table 2); therefore the scores for these were not handed over and collated for this study. Using the AUDIT, a score of 8+ indicates hazardous levels of alcohol use and 16+ is indicative of harmful levels. A score of 16 is the cut-off for alcohol dependency (NICE, 2011) and has a specificity and sensitivity of 94 and 92 respectively (Saunders, Aasland, Babor, de la Fuente, & Grant, 1993).

Data was gathered via semi-structured face-to-face interviews, following consultation with a veteran who stated this would be the preferred method, compared to online methods, in order to build a better rapport. The participant information sheet was reviewed and consent form signed (Appendix D), with any questions answered in order to obtain informed consent. Participants were informed that they could take a break at any time during the interview and may withdraw their data up to the point of analysis. One participant asked for a break. The average length of interviews was 60 minutes 23 seconds. All interviews were audio recorded using a Dictaphone and transcribed verbatim by the researcher to support analysis or a paid

transcriber known to the University of Liverpool. All transcripts were anonymised to ensure confidentiality e.g. all names and locations were altered.

A topic guide was used inform the interviews and provide prompts (Appendix E). However, interviews were person-centred and guided by the exploration of the participant's own lived experiences, aiming to understand their personal meaning. This guide was developed paying attention to IPA guidelines (Smith & Osborn, 2007) and from an understanding of the key features relevant to the research question. An expert by experience (EBE) was also consulted to ensure flow, appropriate language-use and to rule out any ambiguity. An example of a change suggested by the EBE was to alter 'seeking help' to 'working with a service' or 'accessing a service'. Topics covered in the interview included their experience of their difficulties (mental health, alcohol use and TBI), their journey to access services, any barrier or facilitators they experienced (please refer to appendix E for full guide). To elicit additional information, prompts such as 'can you tell me more about that?' were used. Participants were provided with a debrief sheet explaining the study and detailing support (Appendix F).

Data Analysis

Interpretative Phenomenological Analysis (IPA) was used to analyse the data. This explores how a person, in a given context, makes sense of a phenomenon (Smith, 2004), thus using phenomenology, hermeneutics and idiography to understand their personal and social world (Smith, 2010), before drawing generalised conclusions across the larger sample. This exploratory approach facilitated the researcher to make sense of the participant who is making sense of themselves as a veteran with mental health difficulties, a TBI and hazardous/harmful alcohol use, accessing mental health support. IPA includes the description and analysis of lived experience by understanding how meaning is created and exposing

taken-for-granted assumptions (Starks & Trinidad, 2007). The researcher moved between linguistic and psychological exploration, combining what was said by the participant and staying close to their account, with meaning-making and aspects they may not be aware of or wish to share (Smith, 2007). IPA explores what was experienced as well as how it was experienced, which matched the explorative nature of the research questions for this study. IPA draws upon double hermeneutics to facilitate understanding, emphasising the role of the researcher as an interpreter. This acknowledges that the researcher is an active participant as they try to make sense of the participant's meaning and life world, whilst accounting for their preconceptions and fore-understandings (Smith, 2007). The hermeneutic circle between the part and the whole is key to the process of interpretation, emphasising a non-linear method, allowing for deeper analysis (Smith, 2007). Therefore, IPA is iterative and cyclical in nature, as such the researcher constantly engaged with the participant's words through their interpretive lens (Smith, 2007). Additionally, IPA has been used in previous literature within this area (Murphy et al., 2014).

Published IPA guidelines for analysing qualitative data were adhered to (Smith, Flowers, & Larkin, 2009; Smith & Osborne, 2008; Willig 2008), whilst also maintaining the idiosyncratic nature of IPA. Initially, the author became familiar with the transcripts, reading the data multiple times. Detailed notations for 'descriptions' summarising participant's words, 'linguistic comments' exploring language use and 'conceptual comments' capturing the deeper meaning of the words in relation to their lived experiences were added (Appendix G). Next, emergent themes for each interview were established, summarising the participants' own words and the researcher's initial interpretation. Possible interrelationships between emerging themes were examined and those which appeared to be connected were clustered for each individual transcript.

This process was repeated for subsequent transcripts. Themes were then compared across the dataset, paying attention to convergence and divergence. This process generated super-ordinate themes, containing a number of subthemes, whilst keeping meaning at an individual level with the use of direct quotes and interpretations.

Ethics

Ethical approval was granted by the North West Health Research Authority (HRA; Appendix H) in April 2019 (IRAS project ID: 255557). This research was sponsored by University of Liverpool, (sponsorship approved on 18th July 2019) and passed the University of Liverpool review committee (Appendix I), and the trust Research and Development department also granted research and development approval.

Quality and Reflexivity

IPA provides the researcher with an opportunity to engage with the research at an idiographic level, leading to interpretations grounded in the data. However it is subjective (Reid, Flowers, & Larkin, 2005), therefore it is important for the researcher to reflect upon their own experiences and position throughout the research journey to monitor assumptions, fore-conceptions and subjectivities and how these may have impacted analysis (Appendix J for reflexive statement; Appendix K for reflective diary excerpt). Reflexivity is the process of attending to the researcher's influence upon the research, accounting for how their experiences, epistemology and knowledge may interact with the whole process. This covers the questions chosen for interview through to what is highlighted during analysis (Finlay, 2003). Reflexivity, and bracketing, aims to protect against preconceptions and reduce the risk of unclarified biases shaping the data (Ahern, 1999). The researcher identified with the hermeneutic position of researcher as interpreter, and engaged with their interpretations, querying how their personal experience and assumptions may influence each stage. For

example, their prior knowledge of clinical psychological theory or views on access to services for servicemen due to their family connections and wider societal media. This was noted in the reflexive diary. Examples include: *"Is that standing out to me because it fits with my preconceptions that this population need support and a voice to help facilitate change as there is not enough being done for them?",* or *"Am I drawing up theories I feel familiar with due to my experience and training and overlooking other explanations?"*

The authors familiarised themselves with quality frameworks and guidelines, to ensure good practice and trustworthiness of the research (Elliott, Fischer and Rennie, 1999; Lincoln and Guba, 1985; Yardley, 2008). Table 3 illustrates elements of validity by Yardley (2008; 2017) and how each has been addressed in the current study. Yardley is a recommended framework for IPA research (Hefferon & Gil-Rodriguez, 2011).

Table 3
Elements of Validity and the Evidence

Validity element	**How this has been addressed**
Sensitivity to context	The research team were sensitive to the meaning generated by the participants and mindful not to impose pre-conceived ideas on the dataset. The researcher was sensitive to sociocultural and linguistic contexts of the participants, and possible power dynamics, and how this may have influenced what was said and interpretation. A reflexive diary was completed throughout the research process, allowing the researcher's personal experiences and preconceptions to be 'bracketed'. This facilitated an awareness of the researcher's relationship with the research throughout the process.
Commitment and rigour	The author was engaged in the research process throughout, completing all interviews in person, transcribed a portion of transcripts and undertook a detailed in-depth analysis that reflected the principles of IPA. The research team also blind coded a sample of transcripts, with exploratory comments shared and discussed. This process ensured the analysis remained rooted in the lived experiences of veterans.
Transparency and coherence	The researcher followed published IPA guidelines and had regular supervision. Transcripts, notes, reflections and analyses were shared with the research team to facilitate transparency.
Impact and importance	Producing findings that have wider meaning, facilitate clinical use, and inform practice with the field of veteran health was key.

Results

This research aimed to explore the lived experiences of a veteran's journey to accessing mental health services, focusing on males with co-occurring mental health and alcohol difficulties and a TBI. Following IPA guidelines, four super-ordinate themes emerged, a process that must occur in order for veterans to access services, although this may not be linear. Participants experienced 'Denial to acceptance of needing support', with on-going experiences with their 'Sense of self' and 'Knowledge is power', and finally once they accessed services they encountered barriers and facilitators with their 'Relationship with services'. Each have sub-ordinate constituents within them (Table 4). Veterans experienced several internal and external conflicts as barriers and facilitators to accessing support as they moved through the journey. Participants' quotes are used to demonstrate and substantiate findings

Table 4
The Super-ordinate and Sub-ordinate Themes

Super-ordinate themes	Sub-ordinate themes
1. Denial to acceptance of needing support	1.1 Coping strategies
	1.2 Network facilitating acceptance
	1.3 Reaching crisis
2. Sense of self	2.1 Negative self
	2.2 Self-stigma
	2.3 "Who am I?"
	2.4 Self in context of others
3. Knowledge is power	3.1 Lack of awareness
	3.2 Conceptualisations
	3.3 Externalising difficulties
	3.4 Beliefs changing over time
4. Relationship with services	4.1 "*Kicking about*" services
	4.2 Practical and relational considerations

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Theme one: Denial to acceptance of needing support

Veterans spoke about the importance of accepting the need for support before they could access services. Veterans were initially reluctant to accept support from services, believing that they were coping or did not have difficulties to a severity which warranted support. This may have been denial of their experiences and emotions. However, the acceptance of needing support was experienced in various ways: 'coping strategies' which were no longer working, their 'network facilitating acceptance' and 'reaching crisis':

"*I didn't [seek support] for so many years. Ya'know I don't need help, there's nothing wrong me, that sort of thing but when you look back at it and you think well that's not really a rational thing to be doing."* John

Coping strategies

Participants employed various strategies to cope with their experiences, possibly in an attempt to regain control. On occasion, positive strategies were discussed, such as exercise, routine and helping others. However, participants predominantly used defence mechanisms such as avoidance (isolating and withdrawing from society), escapism (alcohol use), denial and violence. This is a barrier to help-seeking as it delays the process:

"*I was using alcohol quite a lot…I buried myself away… so it was too easy for me to do that than go through the stress of trying to sort my head out."* John

Keeping busy to avoid feeling their emotions and "*self-medicating*" (Dave) with alcohol served the purpose of avoidance. Alcohol and violence were also seen as the 'norm' for participants, meaning that these coping strategies were solidified within military culture as acceptable ways of coping. This highlights the importance of social relationships in normalising behaviour, and possible group culture experienced within the military.

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Individuals may have taken up drinking, or increased their alcohol consumption, to 'fit in' with their peers. However, over time participants began to experience a negative impact of using these strategies upon their life and relationships:

"It was only at the point where you start losing all that scaffolding around you that you actually say right you need help." Luke

As Luke expressed, participant's lives were hugely impacted by their experiences and use of these coping strategies. Losing "s*caffolding*" suggests that Luke had lost all the structures and support that was keeping him up and so the need for external support increased. This again highlights the social nature of these experiences. The use of "losing" also triggers emotions of loss and isolation.

Network facilitating acceptance

Participants discussed the impact of their social network in facilitating the acceptance that they needed support. This occurred from both negative (ending of their relationship) and supportive pathways. As mentioned, participants lost key structures; family and friends left, marriages broke down and contact with children was reduced. Participants became aware of the impact on their social network and seeing them upset or their network informing them that they needed support facilitated an acceptance of this:

"Because my Mum…she just looked at me and she just broke down in tears and I just thought I can't do this anymore I need to sort my head out" Matt

"I think it took my wife to sort of say look it's not normal behaviour, it isn't normal, this is what you're doing and you need help." John

Participants also spoke about how military colleagues recognised that they needed support and promoted this:

"…one of the older guys who had been in for quite a while…said 'hey mate you need to get that seen to…that happened to me…get it seen to'." Dave

One participant also spoke about having difficulties with the law facilitating him to access support. Nevertheless, there is a difference between accepting the need to access support and then actually engaging in this, thus demonstrating ambivalence:

"Erm so I've known for a very long time but I think the knowing and the actually dealing with it is something totally totally different." Jack

The following themes continue to explore their experiences of this journey to accessing support.

Reaching crisis

Participants discussed reaching a point of crisis and desperation before accessing services. What this entailed varied between participants as they discussed suicidal ideation, loss of routine, loss of employment and therefore a sense of purpose, and as discussed, the loss of relationships. Unprocessed memories and emotions, a perceived inability to cope, and several losses, many of which are central to their sense of self, caused them to feel utter despair. Four participants explicitly spoke about having had suicidal thoughts and plans to end their own life, feeling overwhelmed and hopeless:

"I took a Lee Enfield Rifle out of my gun cabinet, I'd had enough. So I shoved the gun in my mouth and she walked in just as I was about to pull the trigger…just felt despair all the time…I had nothing in the end. I tried to kill myself 3 times…well I decided in my own head that if I didn't get help I might as well, I was going to definitely kill myself." Peter

One veteran referred to feeling on a "*knives edge*" (Matt). This suggests they were unsure which way things would go: access support services or end their own life,

precariously balancing and waiting for the outcome. This highlights the sensitive nature of their experiences at that time, possibly feeling a lack of control on the outcome. It also invokes emotions such as anxiety, tenseness and inability to relax, which may be reflective of his post-traumatic stress experiences.

One participant felt that they had to reach crisis before any service would meet his needs:

"Unless you're literally going to say you're going to kill yourself I feel that the services are not, they're not accessible enough. Erm, you know, it's taken the fact that I'm I've had to go to self-destruct to get them for the for a mental health service to to deal with me." Matt

Matt believed he needed to be in crisis in order to elicit a response from mental health services. He may have felt like he had to compete for priority but was let down by services with their invalidating, reactive response, and were not responding to his needs as he expected or hoped. This may also be a re-enactment for Matt of earlier childhood experiences and parental attachment.

Theme two: Sense of Self

Throughout the transcripts, veterans alluded to a fragmented sense of self. This included 'negative self-view', 'self-stigma', '*who am I?*' and 'self in context of others'. Therefore, veterans appeared to have an internal battle to create an integrated sense of self, holding negative core beliefs of being "bad", "different", "flawed" and "weak". The difficulties veterans then faced provided 'proof' that they were unable to cope like they 'should' and are the reason for pain within their family.

Negative self-view

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Veterans held various negative views about themselves, their lives and abilities. Participants described low self-worth, being a bad person, not trusting themselves around family and feeling that they could not cope, which affected their sense of self:

"I've just been a whirlwind of self-destruct…I'm very err bad tempered…I've just been a complete tornado for the past four years." Matt

Matt emphasised the self-destructive nature of his behaviour. The use of "*whirlwind*" and "*tornado*" was very powerful in portraying a violent, destructive figure that uproots anything in its path and is the cause of a lot of hurt and devastation for those experiencing it. Tornados are also connected to both the ground and a thunderstorm; this may reflect an inner conflict between feeling grounded and being pulled into the storm of negative self-view, doubt and destruction. Matt may be losing who he is to this 'storm'. This emphasises the broader journey participants experienced, and negative self-views and low self-worth may reduce help-seeking. Matt also repeats "*I've*" and "*I'm*" which stood out as making these claims very personal, self-critical and as though this is who he is now; associated with negative descriptions, he is bad. This awareness appears to cause Matt to feel guilt and shame of his previous actions, triggering low self-esteem.

Self-stigma

Participants used language that illustrated they had internalised shame and stigma and applied it to the self. This included non-disclosure, believing that difficulties suggested weakness and feeling embarrassed:

"you think you're a wuss if you've got PTSD. It's only when you get it then you go I need help…it's like you know you made that bed, you lay in it… it's you know it's not someone else's fault, it's your fault… I was embarrassed because it's, shows a weakness." Luke

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Luke felt personally responsible for his experiences. These beliefs appeared to be enhanced by the lack of support for mental health during his military service. Most veterans stated that mental health was not discussed in the military and the culture was to ridicule anyone experiencing difficulties. This appears to create a sense of shame amongst veterans, causing them to use denial and avoidance to not seem weak to those around them. Luke expressed self-stigma by feeling he had "*made that bed*" so must pay the price and live with the consequences. This, coupled with the internalised belief that soldiers should be able to cope and "*man up*", appeared to elicit stigmatising beliefs. Peter referred to having his "*manhood stripped*" when experiencing mental health difficulties. This invoked thoughts that they may feel emasculated, impotent, powerless and not having the qualities that our society depicts as 'manly'. Therefore, if veterans experience difficulties, this is incongruent with how they feel they "*should*" cope, causing further distress, negative self-beliefs and stigma. Consequently, self-stigmatising beliefs acted as a barrier to help-seeking as they delay access to services.

"*Who am I?*"

Participants spoke about the impact of having joined the military at such a young age, often in adolescence straight from school. This was likened to being "*only a baby*" (John) and a "*clear canvas*" (Dave) when entering the military and that being all they knew. These words suggest a sense of innocence and vulnerability felt when joining the military, and that this life was integral in developing their self-concept. Therefore, since leaving, participants have struggled to adjust their identity, believing they are *"not as good as used to be"* (Luke). This provides a sense of feeling lost, not belonging in this world or even knowing how to relate to themselves anymore. It appears that veterans felt their current self, post military, was not as worthy and did not have as much purpose as the military self. Luke attaches his self-worth and identity with his military career. Some participants appeared to be grieving the loss

of their military identity, yet others assigned experiences of loss to their newer identity of a veteran:

"I've lost quite a lot in the four years I have been, been out of the army, been a veteran." Matt

"Well we have a saying ok what does it feel like, we call it the Shawshank Redemption…he spent all that time in jail and you come out and you're like I've had everything done for me and suddenly I'm Shawshank Redemption." Luke

Luke felt a connection between his experiences and that of a man who was imprisoned and institutionalised, then released into what should be considered freedom, yet feeling he had no skills to cope outside of that institution. This may mirror Luke's feelings of leaving the military and feeling ill-equipped to cope. Luke may have felt overwhelmed, unprepared and lost, unsure of his new role or worth and without the comfort of structure. Luke appeared to place a military job above all others, so since leaving he seemed to have difficulty adjusting his identity and replacing that sense of meaning in his life; a feeling of dissatisfaction with his current life.

"I want a life back, you know, being a, well I'll never be a civilian but just a, in a normal world." Matt

Participants did not identify as civilians, they identified as a veteran and often used "*we*" when referring to themselves in relation to the veteran population. There appeared to be a reluctance to be classified as civilian, and the feeling of difference felt strong; that he does not fit in here. Yet there is a longing for a "*normal world*". Although he doesn't state what a 'normal world' is for him, this feels like a plea for the pain to subside and resentment at his experiences whilst in the forces as he struggles to adjust and make sense of himself.

Participants also used military-related language throughout, such as "*boom*", "*shot*", "*explode*" and "*battle*", demonstrating the connection remained. This sub-theme illustrated a key aspect of participants' journey and that the need for support increased after leaving service due to that support being taken away.

Self in context of others

Veterans spoke about feeling different, to both civilians and other veterans, and felt vulnerable and powerless in context of others. This highlights that their own self-worth is often dependent upon how they see themselves in relation to others. This feeling of difference, 'othering' and social comparison in relation to coping or accessing services hindered an integrated sense of self and impacted participants' journey:

"I just haven't settled into that normal world…I've known people that have done it and they seemed to be to be getting on with it… But unfortunately I just, it just wasn't me… I feel that there's no common ground in between trying to deal with someone who's in my shoes." Matt

It is understood that Matt may have been speaking about having no common ground between himself and family/friends, colleagues and even the researcher. Matt may even be speaking about having no common ground with himself, as he feels so different to the past him and does not understand his own experiences and behaviours, feeling different and defective. The language of '*in my shoes'* also stood out, triggering thoughts about needing to walk a mile in someone's shoes to understand, something Matt feels no-one can do or would want to do, inducing his low self-worth.

Public stigma was also present as a barrier as participants were left feeling that they needed to prove themselves to others or emphasise how extreme their experiences were to justify support:

"Yes because there is a stigma, major stigma around it. People don't want to do it because they think they're going to get the piss took out and not only that it's going to ruin their career." Peter

This was experienced within the interviews. In order to justify accessing services, it appeared that participants felt they had to emphasise the severity of their experiences, through repetition of words. Veterans referred to their mental health difficulties, alcohol misuse and TBI as a "*big thing*", "*huge*" and "*serious*" to convey this message. They may be reflective of their core beliefs surrounding weakness and fearing negative social judgement if this was not conveyed.

Theme three: Knowledge is power

Participants shared insights into their understanding of their experiences, and how this impacted accessing services. Participants' understanding initially appeared low due to a lack of mental health awareness, causing confusion and uncertainty. How participants conceptualised their experiences varied and the use of externalising their difficulties as a defence mechanism emerged, with understanding formed by their past experiences. However, participants noted that their understanding and beliefs about their experiences changed over time, which facilitated them to engage with services.

"…I think understanding that is is is now actually starting to ya'know, I can sort of, not forgive myself, but I can I can understand a lot more of why I've been this way and why I've ya'know I've had these problems." John

Lack of awareness

Participants discussed having low awareness of mental health, alcohol misuse and TBI presentations until they were on this journey themselves:

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"It's been since the injury, yeah, since the injury. I think, I, when you have a head injury, brain injury, I just think it's a snowball effect me. 'cause I had, I probably was a bit ignorant to mental health you know… and now I suffer the way I do." Jack

Participants stated that mental health difficulties were rarely discussed, meaning participants felt that they should be able to cope and did not speak about their experiences; an unrealistic aim, facilitating stigma. Therefore, when they fell short of this and experienced a perceived inability to cope, this was incongruent with that belief, triggering self-criticism and shame. Participants also spoke about being aware they were drinking excessively and becoming increasingly violent, but because that was the 'norm' within military culture, participants were not aware that this may have been indicative of underlying difficulties. Furthermore, one participant shared their experience of having a TBI from a car crash during service, yet this was not followed up at the time and he was not aware of the impact until he had a scan at a later date for a second TBI. Whilst this highlights inconsistency with medical check-ups, this may also have triggered feelings of being neglected and unworthy of having his needs met by those who are supposed to provide care. Therefore, his lack of awareness may be mirrored by others' lack of awareness of his needs. Consequently, accessing services was delayed by normalising beliefs and culture.

Conceptualisations

Participants had varying beliefs and attributions when trying to make sense of their presentation and acceptance of their experiences, with reference to the third sub-aim of this research. Despite experiencing mental health, alcohol misuse and TBI, the majority of the participants focused on psychological difficulties they had experienced, predominantly PTSD. However, it is noted that their experiences of mental health, alcohol misuse and TBI are all interlinked.

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Beliefs about PTSD were a barrier to accessing services as it was discussed as manageable but not curable, and a "*battle*" they will always fight. This engenders feelings of never ending defectiveness, continuous inner conflict and an acceptance of hopelessness and helplessness. Their PTSD is a violent 'battle' they are fighting in their 'war' with life. The language of 'battle' also draws to how their mental health experiences are viewed as comparable to their traumatic military deployment experiences. Similar statements were made in regards to difficulties they experienced as a result of their TBI (memory, concentration). These experiences were likened to a 'vicious cycle'.

Some participants felt confused and ambivalent about their attributions, which may delay accessing services as they were not sure what they were needing support for. This ambivalence may also represent their ambivalence of understanding themselves now, as they cannot make sense their experiences which is such a huge part of them. Participants were still on this journey trying to make sense of their experiences in the interview, acknowledging the complexity and fragility of it:

"Well it was alcohol that caused the head injury…my mental health might have been in a glass box and when I've banged my head its broke that box and it's released it again, I don't know…it's a hard one to to look at." Matt

Use of 'released it again' from a glass box suggests that Matt had unresolved memories and experiences, being contained in a fragile box, and banging his head reflected the banging of this box, breaking and releasing his mental health difficulties.

Participant's experiences with mental health and alcohol were often referred to as 'demons'. This conceptualisation with being 'evil' elicited an insight into the torture that they experienced. It may also reflect their self-concept and core beliefs of being 'bad', and a source of distress, or acknowledging their own inner demons and struggles.

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"… I just used the other demon [alcohol]." Luke

There was a divide in beliefs about experiences of PTSD being linked to childhood. Two participants that shared experiences of childhood trauma (violence and abuse) did believe that their current experiences of PTSD might be rooted in their childhood and triggered again due to their military experiences:

"with regards to my mental health I've had it since I were a child. But it's got worse probably towards the back end of my career erm and obviously the accident…" Matt

However, another participant commented that he did not feel his childhood was relevant in explaining his current experiences; he compartmentalised and distanced these experiences:

"…they just 'oh well because you had a bad childhood it's got to be that.' I said well no, that was fine, I said ok yes so my dad died at the age of four, but I said he didn't die, he was actually killed, but that is nothing to do with the PTSD that I have now because I didn't know about that until I was much older…" Dave

Most participants focused on PTSD and alcohol, although two participants stated that their TBI triggered a decline in their mental wellbeing. Furthermore, Dave framed psychological experiences as more favourable to neurological following the influence from a psychiatrist.

"*…he says it it's just psychological that will be fine, if it's…neurological as in there's something really wrong there then we can't do anything about that*" Dave

Dave felt psychological difficulties could be improved, and therefore is not incurable, unlike a long-standing neurological difficulty. The use of "just psychological" is stigmatising language and dismisses the importance and significance of mental health difficulties,

prioritising a medical model of understanding. Consequently, veterans' beliefs about their experiences impact their journey to accessing services and may be a barrier or facilitator depending on how they conceptualise it.

Externalising difficulties

Across the transcripts participants used clinical language and diagnostic terminology. This provided an insight into how participants processed their difficulties and that having a diagnosis allowed them to name their experiences with a shared language, facilitating help-seeking. However, participants also appeared to externalise their difficulties onto the diagnoses and were an attribution for the diagnosis. This is evident with a number of participants externalising blame from themselves onto their mental health:

"Well I didn't know but it was something to blame… because I didn't know what post-traumatic stress was." Luke

"I wasn't the Dad that I should have been so that's a big big regret and a lot of it is due to my illness." Peter

It was also noted that Luke often spoke about his experiences through others' stories and famous individuals e.g. Prince Harry. This depersonalisation and detachment from their presentation and experiences allowed them to begin processing their core pain and its impact, which may have otherwise been too overwhelming. Nevertheless, this had an impact on beliefs for therapy as participant's expressed that their therapist's job was to "*fix*" them (Dave), again suggesting detached, passive engagement with their recovery. This may also be reflected when Peter used "*illness*", which would fit a medical model of conceptualising his experiences.

Beliefs changing over time

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Veterans reflected that their beliefs and attitudes towards their experiences had changed over time. As discussed, veterans initially held stigmatising beliefs towards their experiences, but later felt that facing their experiences were a strength, and they were able to identify that not all injuries are physical, facilitating an acceptance of mental health difficulties:

"you're weak if you're not well in head you know you're weak but you're not…not anymore I don't [think that], I used to...now I think it's a strength" Peter

Nevertheless, Peter also said that more support needs to be proactively offered whist still in the Armed Forces, but to do so quietly:

"yes well a lot of soldiers obviously they don't have to like broadcast who's going… As long as you can be discreet about it…" Peter

This suggests stigma is still ingrained and although veterans want change, it is within the constraints of secrecy.

Theme four: Relationship with services

Veterans spoke about barriers and facilitators to accessing services. As discussed, veterans had to overcome many personal barriers in order to reach out to services, yet once they did, they experienced further barriers regarding their engagement, re-enacting abandoning and neglectful 'parents'.

"Kicking about" services

Participants described 'kicking about' services, which they referenced as not listening, helping or taking responsibility for them. Consequently, participants may have experienced a lack of security, and felt rejected and abandoned by services:

"So then I sort of lost all faith in it, I'd go from you know from one place to another, I'd go from again like I said psychologist, psychiatrists and I'd be kicking round the system and I just got, everywhere I went I got this [medication]." John

"I blame the military as well because they don't do enough either. They seem to think oh yes once they've gone they've gone that its and it's not it's not right. You know we've been a part of that big massive family for so many years and then we're trashed, we're left alone." Peter

The language of "*kicking about*", feeling overlooked by services by falling through gaps and being left by the military, may have led to a re-enactment of childhood experiences of absence, abandonment and abuse. This appears to be true for Peter as he spoke about military companions as "family" who later were not there for him, and described his childhood experiences, mirroring of the word "kicking" and had absent parents:

"*[my brother] thought he could use me as a kicking bag, which he did. Because my dad worked abroad…my mum was in a, she was working 12 hours a day grafting her arse off and he thought he could do what he wanted…"* Peter

Services may have been perceived in a rejecting role, with participants feeling vulnerable, unsettled and not knowing where they belong or where is a safe place. This would continue barriers to accessing services.

Practical and relational considerations

Several practical and relational considerations emerged, which affected participants' engagement with services. These included factors relating to both the services and the individual. Participants discussed reliance upon word of mouth to discover services that could support them and a lack of support through their G.P. who frequently offered medication, an

invalidating response. Participants also spoke about service resources, staff shortages, long waiting lists, noise during sessions being a distraction and their employment as barriers to accessing services:

"I think what they can offer isn't great. Appointments, lack of appointments, lack of time." Jack

Once participants were working with a service, there were relational barriers and facilitators taken into consideration and acted either as a barrier or facilitator. Feeling listened to and truly understood was important to participants. They wanted a caring, nurturing environment, a safe base, something which they had not experienced previously. There was also a preference for a veteran-specific service or having a therapist who has also served in the military. A need to "prove" them to Peter may reflect his difficulties with trusting others due to his past experiences, and highlights the automatic bond between military personnel:

"The ones that everyone really engaged with were all ex-servicemen…Whereas people who have never served there's some kind of barrier which needs to be overcome… I'm not saying it doesn't get overcome. But for me I won't trust anyone unless they were ex-servicemen, or they had to prove themselves to me." Peter

Summary

Participants experienced various internal and external conflicts whilst accessing mental health services, some of which served as a barrier, whilst others as a facilitator. Initially veterans had to accept the need for support which often took reaching crisis and being prompted by others. Veterans had an on-going journey to overcome a fragmented sense of self, including stigma and social comparison, and to develop an awareness and conceptualisation of their experiences, in order to change perceptions about mental health and

accessing services. Finally, once veterans reached mental health services, they experienced several practical and relational factors which impacted on their engagement and were considered both barriers and facilitators.

Discussion

This research aimed to explore the lived experiences of veterans' journey to accessing mental health services, focusing on those who had co-occurring mental health and alcohol difficulties and a TBI. Following interviews with six participants, IPA elicited four super-ordinate themes: 'Denial to acceptance of needing support', 'Sense of self', 'Knowledge is Power' and 'Relationship with services'. Each theme had between two and four sub-ordinate constituents within them. Various themes identified key insights for the sub-aims regarding the process, barriers and facilitators for this population and their conceptualisations and beliefs about their experiences. Themes appeared to reflect a process of experiences during their journey to accessing services. Many of these seemed to represent experiences of conflict: either inner conflict or external conflict with their social network, the military or services. Participants experienced conflicts such as accepting versus rejecting the need for support, old versus new self, self-stigma versus strength, and motivation to engage. These experiences of 'conflict' veterans have to overcome mirrors the military terminology of being deployed in 'conflicts' such as Afghanistan and Iraq.

Veterans used avoidance, distancing and denial when speaking about coping with their experiences e.g. use of alcohol to supress their threat mode. This highlights how overwhelming and powerful those experiences were and the need for such protective strategies through common defence mechanisms in the short-term (Leiper, 2014). The first theme also appeared to represent elements of the 'stages of acceptance' (Kubler-Ross, 1969), which usually includes denial, anger, bargaining, depression and acceptance. Veterans were in denial of their mental health difficulties and the impact this was having. They were violent and often fought which may be expressions of anger. The veterans also experienced severe distress and plans to end their life, feeling the depression. Finally, once they had survived the depression, they accepted they needed to engage services. Due to the culture in the military,

these stages may help understand the decision process veterans experience before eliciting support. Reaching crisis, awareness of services and the relationship with them, stigmatising beliefs, mental health awareness and practical barriers have previously been identified when exploring experiences of accessing services within veterans with mental health difficulties (Bovin et al., 2019; Kim et al. 2011; Mellotte et al. 2017). Within the current study, reaching crisis often led to suicidal ideation. Barnes, Walter and Chard (2012) concluded that veterans with mild TBI and PTSD may be at increased risk of suicide, which is likely to be mediated or confounded by the severity of PTSD symptomology, compared to PTSD alone. This may explain the incidence of suicidal thoughts in this sample.

Veterans' identity, sense of self, meaning and difficulties with adjustment stood out and may be understood in terms of Erikson's stages of development (Erikson, 1963). During adolescence, individuals face the task of 'identity vs confusion', refining their sense of self by trialling roles which become integrated into their self-concept or causes confusion. Veterans joined the military during this stage, as a "blank canvas", meaning their military life would undoubtedly shape their identity and sense of self. Stage six (intimacy or social isolation) may also account for why veterans would act in accordance with their peers, to avoid social isolation. However, stage seven occurs in middle-aged adults discovering their sense of contribution to the world and due to experiencing all-encompassing mental health difficulties during this time, veterans experience a lack of purpose.

Stigma was apparent within the sample, reflecting the beliefs and experiences found by Coleman et al. (2017). Participants expressed beliefs regarding the masculine military culture and that experiencing these difficulties caused shame and an identity of being "weak". These challenges may be experienced as a fall from 'hero to zero' (Shields, Kuhl, & Westwood, 2017). There appeared to be incongruence between veterans' experiences of military service that promotes masculine qualities such as toughness and self-sacrifice for the

group, and the process of accessing services. Within the military, participants internalised the masculine culture, lack of mental health awareness and beliefs soldiers should be able to cope. Yet when accessing mental health services, veterans were expected to engage in 'talking therapy' and open about their emotions and experiences, with a focus on themselves, not the group. Consequently, the expectation of services may be too much for veterans, who often present to services at crisis (MacManus & Wessely, 2013), when avoidance and escapism strategies are no longer working (Cole et al., 2019). The health beliefs model (Rosenstock et al., 1988) states that a main reason why individuals do not access needed care is the belief 'it's up to me to handle my own problems' which aligns with this masculine military culture. Graziano and Elbogen (2017) found that 42% of veterans endorsed this belief, which negatively affected accessing services in the US.

Participants' conceptualisations of their experiences were intrinsically connected to historical experiences of trauma and stigma, thus influencing their schemas of what mental health difficulties are. Themes and subthemes identified within this sample aligned with these previous studies that have explored accessing services within veterans with mental health difficulties, despite the addition of TBI in this study. This may reflect the overlap between PTSD and TBI experiences and 'symptomology' (Snell & Halter, 2010), meaning that experiences of accessing services are similar to previous studies without explicit TBI inclusion. Additionally, participants perceived alcohol misuse as part of the military culture and a coping strategy, which aligns with previous research (Besse et al., 2018; Fraser et al., 2017).

Several elements of this research highlighted social relationships, running through all themes and often illustrated parallels and re-enactments between the veteran feeling vulnerable, as a child is, and experiencing absent, neglectful parents and services. Secure attachment has been linked with emotion regulation, positive self-concept and pro-social

behaviours (Cassidy & Shaver, 2008). However, veterans experienced abusive and neglectful childhoods and had a negative self-concept and engaged in antisocial behaviours (fighting, violence and alcohol misuse). Therefore, the participant's may not have developed these positive concepts, accounting for the activation of attachment behaviour during threat, e.g. living with PTSD, and the need for a caring, nurturing response from others. However, services often were unable to provide this secure response when needed. Another element of the social relationships was evident as veterans compared themselves to colleagues, family members and famous people, which can often lead to dissatisfaction and guilt. This can be understood in terms of the Social Comparison Theory (Festinger, 1954), basing their own worth on how they evaluate themselves in comparison to others. Therefore, this negatively impacts their self-concept due to negative judgements.

Unlike previous literature that stated veterans predominantly conceptualise their co-occurring experiences with biological causes (King et al., 2018), participants within this sample focused on the psychological experiences more than their TBI. The current study also found that participants used clinical and diagnostic terminology, which is different to previous qualitative studies exploring expressions of emotional distress where that was rarely used (Cole et al., 2019). This difference may be the result of participants having accessed and been recruited through a mental health service, and in response to having been interviewed by a trainee clinical psychologist. Therefore, veterans may have compartmentalised their experiences and spoke about mental health more than TBI due to the context in which this research was completed. Nevertheless, two participants referenced the impact their TBI had on their mental health, and TBI is a known risk factor for post-traumatic stress and depression (Cole & Bailie, 2015; Riggio, 2011). Participants' discussed their experiences and coping strategies in alignment with the diagnostic criteria for PTSD e.g. avoidance, using alcohol to

supress their hyperarousal and threat systems, ‘fight’ of the fight/flight response was evident with the violence and negative cognitions and mood (APA, 2013).

This is the first study to provide an interpretative account of veterans’ experiences of accessing mental health services, with mental health difficulties, alcohol misuse and TBI. It is a subjective interpretation of a small number of veterans; therefore, it aims to be transferable (Lincoln & Guber, 1985), but it does not aim to be generalisable, which could be viewed as a limitation. All participants were male veterans, with the majority having served in the Army. Therefore, this study may not transfer to experiences of female veterans or other military branches. Future studies may wish to explore the experiences of female veterans with this multi-morbidity presentation.

Recruiting through one veteran-specific mental health service enabled some consistency with service pathways, thus facilitating homogeneity of the sample experiences, and facilitated access to a population that by nature is hard to reach (Fossey, Harvey, McDermott, & Davidson, 2002). Additionally, the service used covers veteran mental health for the whole of the North West of England, so even though it is one service it is a large service, covering a large geographical area. However, this may have limited the perspectives on barriers to support, and other veterans may have successfully accessed charities or mainstream NHS services meaning their experiences were missed. Nevertheless, the topic guide was designed to ask participants to reflect on their experiences of accessing services other than just the NW site. Furthermore, it must be acknowledged that there may be veterans experiencing barriers and have not yet accessed services, meaning their experiences are not captured. It would be interesting to explore these three morbidities with veterans who have not yet accessed services, although the difficulty for recruitment is acknowledged. Recruiting through other avenues such as mainstream NHS services, charities or online forums, rather

than recruiting through a veteran-specific service, to include veterans with varying levels of need would further add to this literature.

It is documented that veterans do not access services routinely, and even fewer are likely to engage in research, meaning the purposive sampling methods may have favoured a certain type of person. Recruiting veterans that self-identified as having experienced a TBI, through a mental health service, may have failed to capture the experiences of veterans who did not wish to speak about their experiences. Furthermore, as participants were recruited through a service they were receiving, or waiting to receive support from, they may have been influenced by the researcher through interviewer effects.

Implications

This study has several implications for clinical practice, services and policy guidelines. Veterans generally disclosed negative experiences of accessing both charities and NHS services, although there were variances in this. Veterans felt abandoned by the Armed Forces, yet, they had not adjusted to civilian life and therefore did not know where or how to help. This highlights the need for more awareness and understanding of mental health within the Armed Forces, and transition support for veterans. One participant spoke about their G.P having posters about veteran mental health, which had a positive impact. Themes relating to veterans' journey of help-seeking and barriers and facilitators related to accessing services and engagement with services. Consequently, promoting both access to services, which was the main aim of this study, and engagement with services is key. Earlier recognition of difficulties may cause earlier engagement with services, as veterans often had reliance upon their support network to facilitate access. Therefore, it is also important to increase family members' awareness of available support for themselves and the veteran (HM Government, 2018; MoD, 2019). It has been reported that military spouses/partners are significantly more likely to meet criteria for depression and hazardous alcohol consumption, than woman in the

general population (Gribble, Goodwin & Fear, 2019). It is also important to include the support network in therapeutic interventions as the veteran exists within a relational and cultural context, which must be considered (Doncaster, Hiskey, McPherson & Andrews, 2019).

Within the Strategy for Our Veterans (HM Government, 2018), the first principle is that "*veterans are first and foremost civilians…"*, however, this study provided opposing views from the veterans who stated that they will never be a civilian. Furthermore, veterans spoke about a lack of consistency and collaboration between services, which is contradictory to a key factor for service provision documented in this strategy. Therefore, incongruence is evident between veterans who are going through their help-seeking journey and policy. Consequently, more work needs to be implemented to try and close this gap.

This thesis refers to 'help-seeking' as veterans who have accessed services and explores their experiences of getting to that point. Literature uses the term 'help-seeking', however it was noted that veterans may not like or use this term themselves. The expert by experience that was consulted for the empirical paper stated that he did not like using the term 'help'. Therefore, there appears to be a gap between current literature and the veterans this literature is representing. This highlights the importance of bridging this gap between research literature and the clients, and the role of engaging with experts by experience for meaningful insights.

Clinicians could use the themes that emerged to understand internal and external conflicts their clients may be experiencing throughout their help-seeking journey. Factors identified in this study may be dynamic throughout engagement. These themes may provide insight for clinicians if they are experiencing barriers with their clients. This study also provides a conceptualisation of veterans with this multi-morbidity presentation, from their

lived experiences and beliefs. One participant asked for a break and memory difficulties were discussed within interviews, which highlights the importance to ensure clients' needs are met regarding the physical set up of sessions, accounting for their concentration, fatigue and memory difficulties.

Conclusion

This study provided an IPA insight of veterans' experiences to accessing mental health services, with mental health difficulties, alcohol misuse and TBI. Themes highlighted the overall journey veterans' experienced, key barriers and facilitators to help-seeking as well as their conceptualisation and beliefs about their experiences. Themes emphasised the importance of promoting both access to services and engagement with services, which aligns with previous research. Less cited in previous literature was the focus on psychological, rather than biological experiences, and conceptualisations with co-morbid mental health, alcohol misuse and TBI. Ongoing programmes to facilitate engagement with veterans are needed as many of the barriers to accessing services presented here were evident in previous research from a decade ago. This research can be used by clinicians to facilitate an understanding of the journey veterans experience and factors which are important to them in help-seeking.

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Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

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Author Guidelines updated 14th October 2019

Appendix B: QATSDD Scale

Table 1 Quality assessment tool and scoring guidance notes

Criteria	0 = Not at all	1 = Very slightly	2 = Moderately	3 = Complete
Explicit theoretical framework	No mention at all.	Reference to broad theoretical basis.	Reference to a specific theoretical basis.	Explicit statement of theoretical framework and/or constructs applied to the research.
Statement of aims/objectives in main body of report	No mention at all.	General reference to aim/objective at some point in the report including abstract.	Reference to broad aims/objectives in main body of report.	Explicit statement of aims/objectives in main body of report.
Clear description of research setting	No mention at all.	General description of research area and background, e.g. 'in primary care'.	General description of research problem in the target population, e.g. 'among GPs in primary care'.	Specific description of the research problem and target population in the context of the study, e.g. nurses and doctors from GP practices in the east midlands.
Evidence of sample size considered in terms of analysis	No mention at all.	Basic explanation for choice of sample size. Evidence that size of the sample has been considered in study design.	Evidence of consideration of sample size in terms of saturation/information redundancy or to fit generic analytical requirements.	Explicit statement of data being gathered until information redundancy/saturation was reached or to fit exact calculations for analytical requirements.
Representative sample of target group of a reasonable size	No statement of target group.	Sample is limited but represents some of the target group or representative but very small.	Sample is somewhat diverse but not entirely representative, e.g. inclusive of all age groups, experience but only one workplace. Requires discussion of target population to determine what sample is required to be representative.	Sample includes individuals to represent a cross section of the target population, considering factors such as experience, age and workplace.
Description of procedure for data collection	No mention at all.	Very basic and brief outline of data collection procedure, e.g. 'using a questionnaire distributed to staff'.	States each stage of data collection procedure but with limited detail, or states some stages in details but omits others.	Detailed description of each stage of the data collection procedure, including when, where and how data were gathered.
Rationale for choice of data collection tool(s)	No mention at all.	Very limited explanation for choice of data collection tool(s).	Basic explanation of rationale for choice of data collection tool(s), e.g. based on use in a prior similar study.	Detailed explanation of rationale for choice of data collection tool(s), e.g. relevance to the study aims and assessments of tool quality either statistically, e.g. for reliability & validity, or relevant qualitative assessment.
Detailed recruitment data	No mention at all.	Minimal recruitment data, e.g. no. of questionnaire sent and no. returned.	Some recruitment information but not complete account of the recruitment process, e.g. recruitment figures but no information on strategy used.	Complete data regarding no. approached, no. recruited, attrition data where relevant, method of recruitment.
Statistical assessment of reliability and validity of measurement tool(s) (Quantitative only)	No mention at all.	Reliability and validity of measurement tool(s) discussed, but not statistically assessed.	Some attempt to assess reliability and validity of measurement tool(s) but insufficient, e.g. attempt to establish test–retest reliability is unsuccessful but no action is taken.	Suitable and thorough statistical assessment of reliability and validity of measurement tool(s) with reference to the quality of evidence as a result of the measures used.
Fit between stated research question and method of data collection (Quantitative)	No research question stated.	Method of data collection can only address some aspects of the research question.	Method of data collection can address the research question but there is a more suitable alternative that could have been used or used in addition.	Method of data collection selected is the most suitable approach to attempt answer the research question
Fit between stated research question and format and content of data collection tool e.g. interview schedule (Qualitative)	No research question stated.	Structure and/or content only suitable to address the research question in some aspects or superficially.	Structure & content allows for data to be gathered broadly addressing the stated research question(s) but could benefit from greater detail.	Structure & content allows for detailed data to be gathered around all relevant issues required to address the stated research question(s).
Fit between research question and method of analysis	No mention at all.	Method of analysis can only address the research question basically or broadly.	Method of analysis can address the research question but there is a more suitable alternative that could have been used or used in addition to offer greater detail.	Method of analysis selected is the most suitable approach to attempt answer the research question in detail, e.g. for qualitative IPA preferable for experiences vs. content analysis to elicit frequency of occurrence of events, etc.
Good justification for analytical method selected	No mention at all.	Basic explanation for choice of analytical method	Fairly detailed explanation of choice of analytical method.	Detailed explanation for choice of analytical method based on nature of research question(s).
Assessment of reliability of analytical process (Qualitative only)	No mention at all.	More than one researcher involved in the analytical process but no further reliability assessment.	Limited attempt to assess reliability, e.g. reliance on one method.	Use of a range of methods to assess reliability, e.g. triangulation, multiple researchers, varying research backgrounds.
Evidence of user involvement in design	No mention at all.	Use of pilot study but no involvement in planning stages of study design.	Pilot study with feedback from users informing changes to the design.	Explicit consultation with steering group or statement or formal consultation with users in planning of study design.
Strengths and limitations critically discussed	No mention at all.	Very limited mention of strengths and limitations with omissions of many key issues.	Discussion of some of the key strengths and weaknesses of the study but not complete.	Discussion of strengths and limitations of all aspects of study including design, measures, procedure, sample & analysis.

Appendix C: Participant Information Sheet

IRAS Number: 255557 Version 4.1: 16.04.19

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Participant Information Sheet

Title of Study: Exploring how Veterans who have a traumatic brain injury and use alcohol experience mental health services

Researchers: Charlotte Gayson, Dr Laura Goodwin and Dr Warren Donnellan

Dear prospective participant,

I am inviting you to take part in a research study. Before you decide whether you want to participate, it is important for you understand why this research is being done and what it will involve. Please take time to read the following information sheet carefully and feel free to contact the researcher to ask questions if there is anything that you do not understand. Please also feel free to discuss your participation with other people if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

1. **What is the purpose of the study?**

This research is being conducted by the University of Liverpool.

The purpose of this study is to explore how veterans who report a service-related head injury (also known as traumatic brain injury [TBI]) and use/have used alcohol heavily, experience mental health services. This research aims to promote better understanding of veteran's experiences of mental health services and understand if the current service is suitable for veterans accessing mental health services with this presentation.

2. **Why have I been chosen to take part?**

You have been informed about this study because during the assessment process at Military Veterans' Service, you agreed to be contacted about future research opportunities. Our aim is to interview veterans about your experiences of accessing support, using the service and your presentation.

The additional eligibility criteria are:

- 18+
- Have served in the UK military
- Self-report a service-related head injury (also known as a traumatic brain injury [TBI], which can be described as either mild or major. Mild head injury is the most common form of head injury which is why this is the focus of the current research. The term 'concussion' can also be used for mild TBI).
- Use alcohol and scored at least 8+ on the Alcohol Use Disorders Identity Test (AUDIT)

- Speak fluent English for the purposes of the interviews
- Have capacity to consent to participation

You have either self-identified with the study criteria, or a clinical staff member has noticed in your NHS notes you wish to take part in research and meet the criteria.

3. Do I have to take part?

Participation is voluntary, you are under no obligation to take part in this study. If you decide to take part, 1) you will be able to retain this information sheet and a copy of the consent form and 2) you are free to withdraw at any time, until the data has been made anonymous and used for analysis. If you decide to withdraw, you will not need to provide an explanation, and this will not disadvantage you or your access to services.

4. What will happen if I take part?

If you wish to take part, either inform a member of the clinical team if you are happy for them to pass on your information or email the lead researcher directly (charlotte.gayson@liverpool.ac.uk) expressing your interest. The lead researcher will then get in contact with you to organise a face-to-face interview, which will take place at a time and location suitable for you. The interview will take place with the lead researcher (Charlotte Gayson), take the form of a semi-structured interview and is estimated to last approximately 45-60 minutes.

5. How will my data be used?

Only staff at the Military Veterans' Service will access any NHS client records if required. The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public tasks', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit."

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The Principal Investigator acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to charlotte.gayson@liverpool.ac.uk. You can find out more about how we use your information at https://www.liverpool.ac.uk/legal/data_protection/.

Further information on how your data will be used can be found in the table below.

How will my data be collected?	This study will include one-to-one interviews which will be audio recorded.
How will my data be stored?	The audio recording and transcriptions of the interviews will be stored on a password protected computer and deleted once transcribed and anonymised. The consent form will be stored in a locked cabinet in Dr Laura Goodwin's office, University of Liverpool.
How long will my data be stored for?	10 years, as per the University of Liverpool

	protocol.
What measures are in place to protect the security and confidentiality of my data?	Once signed, the consent form will be placed into an envelope and sealed until the researcher is back on site. You will then be assigned a unique participant number to ensure confidentiality. All data will be stored securely as mentioned above.
Will my data be anonymised?	Yes, your data will be anonymised, so you will not be identifiable.
How will my data be used?	Your data will be anonymised, and themes will be pulled out from all participants' interviews. Themes and quotes will be written up in a report for publication. You and your data will not be identifiable.
Who will have access to my data?	The research team will have access to your data.
Will my data be archived for use in other research projects in the future?	No, your data will be archived following completion of the project, following the University of Liverpool protocol and then destroyed. It will not be used for other research.
How will my data be destroyed?	The audio recording of the interview will be destroyed once transcribed and anonymised. The paper data (consent form and anonymised transcripts if printed) will be shredded.

6. Expenses and / or payments

All efforts will be made to meet at a time and location convenient to you. The Military Veterans' Service use various locations within the North West, such as fire stations and libraries as well as NHS premises, for meetings. You will be reimbursed for travel to the location to participate (up to the cost of £10). In addition to this, you will be provided with a £15 voucher as recompense for your time.

7. Are there any risks in taking part?

There are unlikely to be any direct risks to you if you take part in this study. However, if you have any negative experiences because of taking part in this study, or if you are not comfortable with any of the questions in the interview, please let the researcher know immediately. There is a risk protocol in place and if you feel the need to speak to someone following the interviews, a call back will be offered within 24 hours of the interview, by a clinical member of the Military Veterans' Service. If the interview is to occur on a Friday, then please note the Military Veterans' Service is shut over the weekend and a call back will be the next working day.

8. Are there any benefits in taking part?

There are no direct benefits to taking part, however this research aims to inform practices within veterans' mental health services, by gaining an understanding of veteran's current experiences. Therefore, participants may benefit from being involved in contributing to and

shaping research within this area, and the service practice at this service and similar services within the UK.

9. What will happen to the results of the study?

The interview data will be stored using a unique participant number. The electronic data will be stored in password-protected files. Following completion of the study, it is anticipated that the results will be published in a scientific journal and shared at appropriate conferences. Reports will contain a summary of results from all of the participants who take part; you will not be identified by name.

10. What will happen if I want to stop taking part?

You are free to withdraw from this study, without explanation. Results up to the period of withdrawal may be used, if you are happy for this to be done. Otherwise you may request that your results are destroyed, and no further use is made of them. Once your data from your interview transcripts have been transcribed and anonymised, then it will not be possible for us to exclude your data from the results. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

11. What if I am unhappy or there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Charlotte Gayson or Laura Goodwin (details at the end) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

12. Who can I contact if I have further questions?

If you have any questions, then please contact the principal investigator or student investigator at the University of Liverpool:

Chief Investigator
Dr Laura Goodwin
School of Psychology,
University of Liverpool, L69 7ZA
0151 795 8730
laura.goodwin@liverpool.ac.uk

Student Investigator
Charlotte Gayson
Doctorate in Clinical Psychology
University of Liverpool, L69 3GB
0151 794 5102
charlotte.gayson@liverpool.ac.uk

Thank you for taking the time to read this.

Appendix D: Consent Form

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Participant Consent Form

Version 4.1 (16th April 2019)
Research ethics approval number: 255557
Title of the research project: Exploring how Veterans who have a traumatic brain injury and use alcohol experience mental health services
Name of researcher(s): Charlotte Gayson, Dr Laura Goodwin and Dr Warren Donnellan

Please initial box

1. I confirm that I have read and have understood the information sheet dated 22nd January 2019 for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any particular question or questions. ☐
3. I understand that the research team will not access my NHS records, only the NHS staff team will access any NHS records if needed. ☐
4. I understand and agree that my participation will be audio recorded and I am aware of and consent to your use of these recordings for the following purposes: to be transcribed by the research team and a professional transcriber, anonymised, analysed by the research team and quotes used in the write up. ☐
5. I understand that the original recording will be deleted once it has been transcribed, and that a transcript of my interview will be retained for 10 years as per the University of Liverpool protocol. ☐
6. I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool until it is fully anonymised. ☐
7. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my fully anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. ☐
8. I understand that I can ask for access to the information I provide and I can request the destruction of that information if I wish at any time, prior to anonymization. I understand that following anonymization I will no longer be able to request access to or withdrawal of the information I provide. ☐
9. I understand that personal information collected about me that can identify me, such as my name or where I live, will not be shared beyond the research team. ☐
10. I understand that signed consent forms will be retained in Dr Laura Goodwin's office at the University of Liverpool in a locked cabinet. The data custodian (Dr Laura Goodwin) will be responsible for the data for a minimum of ten years, following university policy. ☐

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NHS LOGO

11. The information you have submitted will be published as a report; please indicate whether you would like to receive a copy. ☐

12. I agree to take part in the above study. ☐

Participant name	Date	Signature
Name of person taking consent	Date	Signature

Principal Investigator
Dr Laura Goodwin
School of Psychology,
University of Liverpool, L69 7ZA
0151 795 8730
Laura.goodwin@liverpool.ac.uk

Student Investigator
Charlotte Gayson
Doctorate in Clinical Psychology
University of Liverpool, L69 3GB
0151 794 5102
charlotte.gayson@liverpool.ac.uk

Appendix E: Topic Guide

IRAS Number: 255557 Version 4: 24/5/19

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Topic Guide

Thank you for agreeing to talk about your experiences of living with mental health difficulties, alcohol use and head injury, and accessing the military veterans service. I am interested in your own personal experience which may be different from other peoples, so tell me what it has been like for you. I would like to record the conversation with your permission. We will be able to arrange an opportunity for you to hear the recording if you would like. Should you wish to stop the interview at any time, or take a break, please tell me. Because the topic of our discussions is sensitive I can assure you that it will remain confidential.

First of all, I would like to ask you some factual questions and then some more open questions about your experiences.

1. Initial factual questions:

- What is your year of birth?
- Which military service were you a part of?
- How long were you in the military?
- Have you accessed any other psychological services before the military veteran's service?
- Can you tell me briefly about the nature of your head injury/concussion?

2. Can you tell me about when you left service?

- What led to you leaving the military?
- How long has it been since you left the military?

3. What were the difficulties you experienced and led to working with MVS or other services previously?

- What difficulties were you experiencing at the time you accessed services?
- You self-identify as having experienced a head injury, can you tell me a little bit more about that?
- Can you tell me about how you use alcohol and how this may have changed?

4. Can you tell me a bit more about how you experience the difficulties we have just been talking about?

- How do you understand/make sense of what you were experiencing and your difficulties which led to working with services (mental health, head injury and alcohol use)?
- Has how you experience and understand your presentation/difficulties changed over time? Do you think/feel differently about them?

5. Can you tell me about your experience of working with MVS or any other service?

- Was it something you sought out or was suggested to you?
- What were your expectations prior to accessing this service?
- Can you tell me about anything that helped you to access support?
- What helped you to access the military veteran's service/how did you hear about it?
- Was there anything that you found difficult about your decision to access support?
- Were there any barriers you experienced when trying to access support?

6. Do you think these difficulties, or how you thought about them, impacted upon you access services?

- Did this impact on how quickly you accessed support?

7. What has been beneficial/helpful for you when working with the service?

8. Taking your experience into account, are there any changes you can think of that might improve the process and experience of accessing services for others?

9. Is there any advice you give to someone else who is in the same position?

10. Is there anything else you wish to add which has been missed, or have any questions for me?

Appendix F: Debrief sheet

IRAS Number: 255557 Version 1: 05.03.19

UNIVERSITY LOGO

Participant Debrief Sheet

Title of Study: Exploring how Veterans who have a traumatic brain injury and use alcohol experience mental health services

Researchers: Charlotte Gayson, Dr Laura Goodwin and Dr Warren Donnellan

Why is this study taking place?

There are approximately 2.5 million UK armed forces veterans residing within Great Britain. Approximately one in five have a mental health difficulty, but over half do not seek help for this. Additionally, alcohol use has been found to be more common in UK Armed forces than the general population but help-seeking for alcohol use is lower than seeking help for mental health difficulties within the UK Armed forces.

Head injuries have been reported as 'signature wounds' of recent wars, with high numbers of military personnel experiencing both head injuries and mental health difficulties. It is thought that this more common in veterans than civilians. A recent study in the USA reported that over three quarters of service users seeking help at a mental health service reported mental health difficulties, substance use and a head injury.

Previous research has looked at what stops veterans from seeking support for mental health difficulties. However, there has been little focus on what helps individuals come forward and seek support. Also, there has not been any interview research into this for veterans who experience mental health difficulties, alcohol use and head injury. However, the number of individuals experiencing mental health difficulties, alcohol use and a head injury together has been increasing. Therefore, it is important to understand the experiences of these individuals to improve staff knowledge and future support.

What happens next?

Recruitment will continue until we reach the required number of participants to provide a rich enough dataset and meet the aims of this research. It is estimated that this may be approximately 8-12 participants. The interview data will be stored using a unique participant number. The electronic data will be stored in password-protected files.

The interviews will be transcribed by the student researcher and a professional transcriber known to the university. The transcripts will then be analysed via interpretive phenomenological analysis (IPA) by the student researcher. This approach involves the description and analysis of lived experience by understanding how meaning is created. This analysis captures meaning and common features of experiences, analysing and categorising statements into clusters that represent the phenomenon.

Following completion of the study, it is anticipated that the results will be published in a scientific journal and shared at appropriate conferences. Reports will contain a summary of results from all the participants who take part; you will not be identified by name.

What to do if you are unhappy or there is a problem

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Charlotte Gayson or Laura Goodwin (details at the end) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

If you need to speak to someone:

Following the interviews, you may wish to speak to a clinical staff member. As part of the study you can ask for a call from a clinical staff member from the Military Veteran's Service. This will take place within 24 hours of the interview ending, Monday – Friday between 9am and 5pm.

Other services which may be useful include:

- Samaritans: call 116 123 from any phone
- Contact your GP

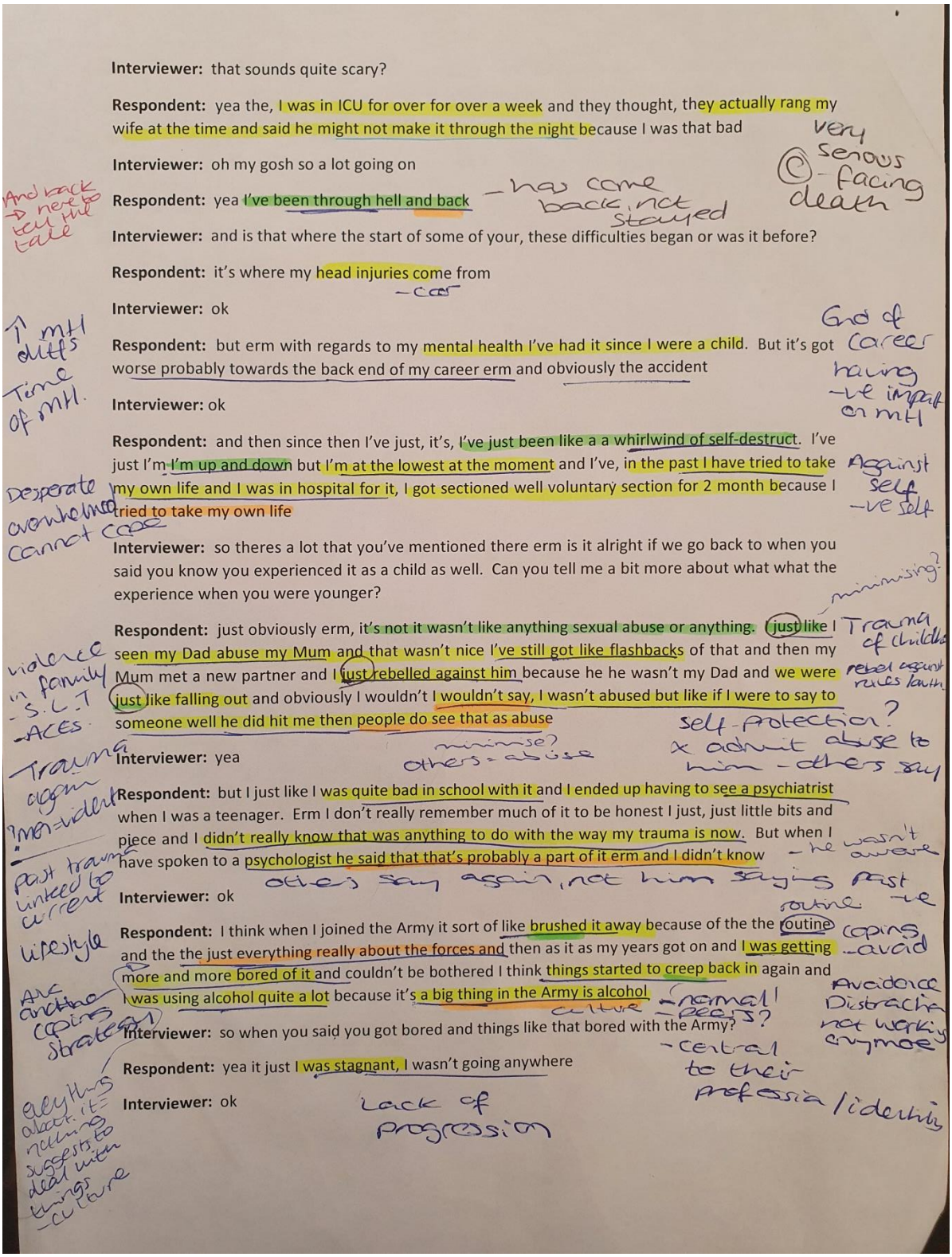
If you have any questions, then please contact the chief investigator or student investigator at the University of Liverpool:

Chief Investigator
Dr Laura Goodwin
School of Psychology,
University of Liverpool, L69 7ZA
0151 795 8730
laura.goodwin@liverpool.ac.uk

Student Investigator
Charlotte Gayson
Doctorate in Clinical Psychology
University of Liverpool, L69 3GB
0151 794 5102
charlotte.gayson@liverpool.ac.uk

Thank you for taking the time to participate in this research.

Appendix G: Transcript sample with descriptive, linguistic and interpretative comments



Interviewer: that sounds quite scary?

Respondent: yea the, I was in ICU for over for over a week and they thought, they actually rang my wife at the time and said he might not make it through the night because I was that bad

Interviewer: oh my gosh so a lot going on

Respondent: yea I've been through hell and back

Interviewer: and is that where the start of some of your, these difficulties began or was it before?

Respondent: it's where my head injuries come from

Interviewer: ok

Respondent: but erm with regards to my mental health I've had it since I were a child. But it's got worse probably towards the back end of my career erm and obviously the accident

Interviewer: ok

Respondent: and then since then I've just, it's, I've just been like a a whirlwind of self-destruct. I've just I'm I'm up and down but I'm at the lowest at the moment and I've, in the past I have tried to take my own life and I was in hospital for it, I got sectioned well voluntary section for 2 month because I tried to take my own life

Interviewer: so theres a lot that you've mentioned there erm is it alright if we go back to when you said you know you experienced it as a child as well. Can you tell me a bit more about what what the experience when you were younger?

Respondent: just obviously erm, it's not it wasn't like anything sexual abuse or anything. I just like I seen my Dad abuse my Mum and that wasn't nice I've still got like flashbacks of that and then my Mum met a new partner and I just rebelled against him because he he wasn't my Dad and we were just like falling out and obviously I wouldn't I wouldn't say, I wasn't abused but like if I were to say to someone well he did hit me then people do see that as abuse

Interviewer: yea

Respondent: but I just like I was quite bad in school with it and I ended up having to see a psychiatrist when I was a teenager. Erm I don't really remember much of it to be honest I just, just little bits and piece and I didn't really know that was anything to do with the way my trauma is now. But when I have spoken to a psychologist he said that that's probably a part of it erm and I didn't know

Interviewer: ok

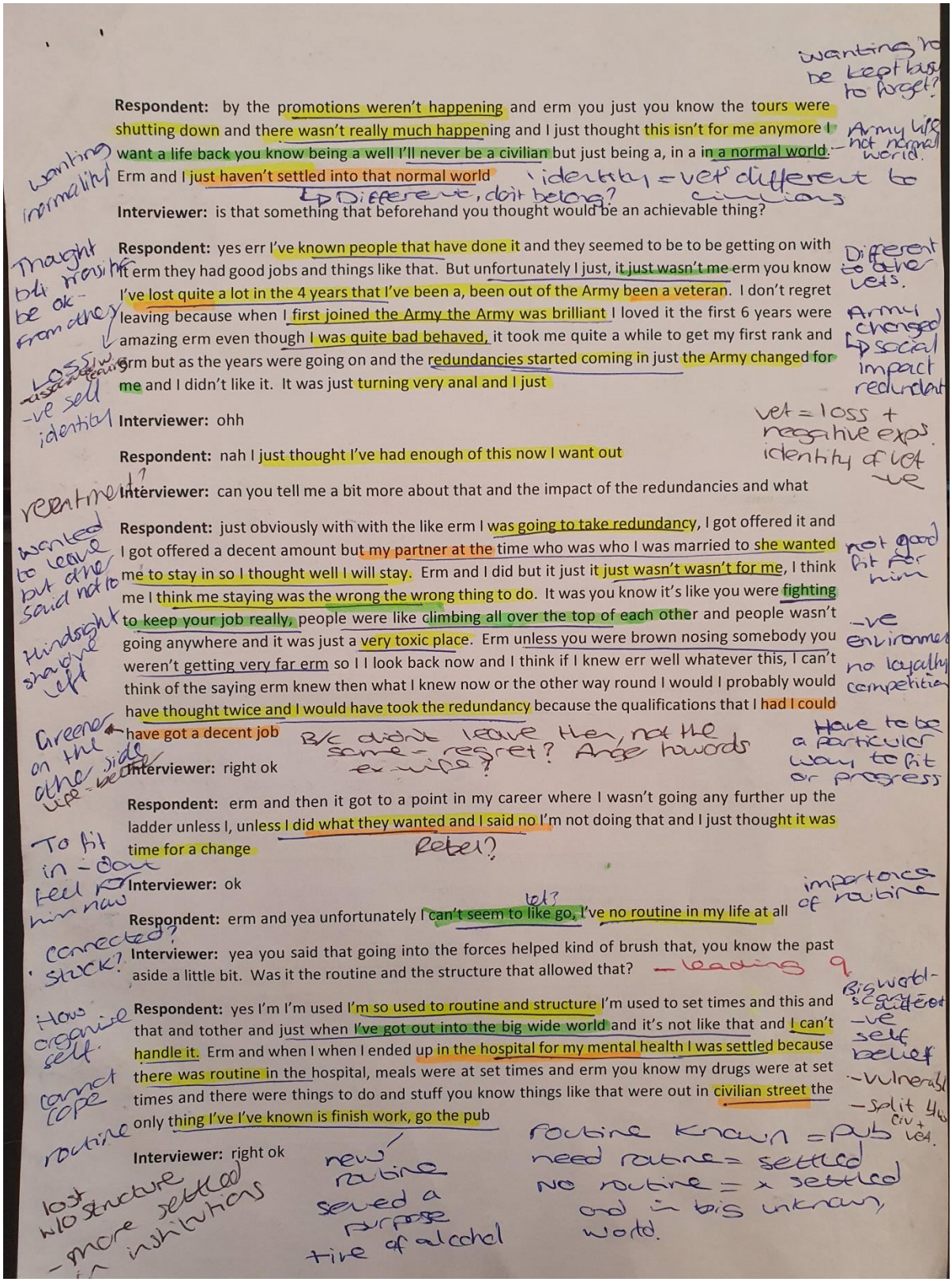
Respondent: I think when I joined the Army it sort of like brushed it away because of the the routine and the the just everything really about the forces and then as it as my years got on and I was getting more and more bored of it and couldn't be bothered I think things started to creep back in again and I was using alcohol quite a lot because it's a big thing in the Army is alcohol

Interviewer: so when you said you got bored and things like that bored with the Army?

Respondent: yea it just I was stagnant, I wasn't going anywhere

Interviewer: ok

EXPERIENCES OF ACCESSING SERVICES



Respondent: by the promotions weren't happening and erm you just you know the tours were shutting down and there wasn't really much happening and I just thought this isn't for me anymore I want a life back you know being a well I'll never be a civilian but just being a, in a in a normal world. Erm and I just haven't settled into that normal world

Interviewer: is that something that beforehand you thought would be an achievable thing?

Respondent: yes err I've known people that have done it and they seemed to be to be getting on with it erm they had good jobs and things like that. But unfortunately I just, it just wasn't me erm you know I've lost quite a lot in the 4 years that I've been a, been out of the Army been a veteran. I don't regret leaving because when I first joined the Army the Army was brilliant I loved it the first 6 years were amazing erm even though I was quite bad behaved, it took me quite a while to get my first rank and erm but as the years were going on and the redundancies started coming in just the Army changed for me and I didn't like it. It was just turning very anal and I just

Interviewer: ohh

Respondent: nah I just thought I've had enough of this now I want out

Interviewer: can you tell me a bit more about that and the impact of the redundancies and what

Respondent: just obviously with with the like erm I was going to take redundancy, I got offered it and I got offered a decent amount but my partner at the time who was who I was married to she wanted me to stay in so I thought well I will stay. Erm and I did but it just it just wasn't wasn't for me, I think me I think me staying was the wrong the wrong thing to do. It was you know it's like you were fighting to keep your job really, people were like climbing all over the top of each other and people wasn't going anywhere and it was just a very toxic place. Erm unless you were brown nosing somebody you weren't getting very far erm so I I look back now and I think if I knew err well whatever this, I can't think of the saying erm knew then what I knew now or the other way round I would I probably would have thought twice and I would have took the redundancy because the qualifications that I had I could have got a decent job

Interviewer: right ok

Respondent: erm and then it got to a point in my career where I wasn't going any further up the ladder unless I, unless I did what they wanted and I said no I'm not doing that and I just thought it was time for a change

Interviewer: ok

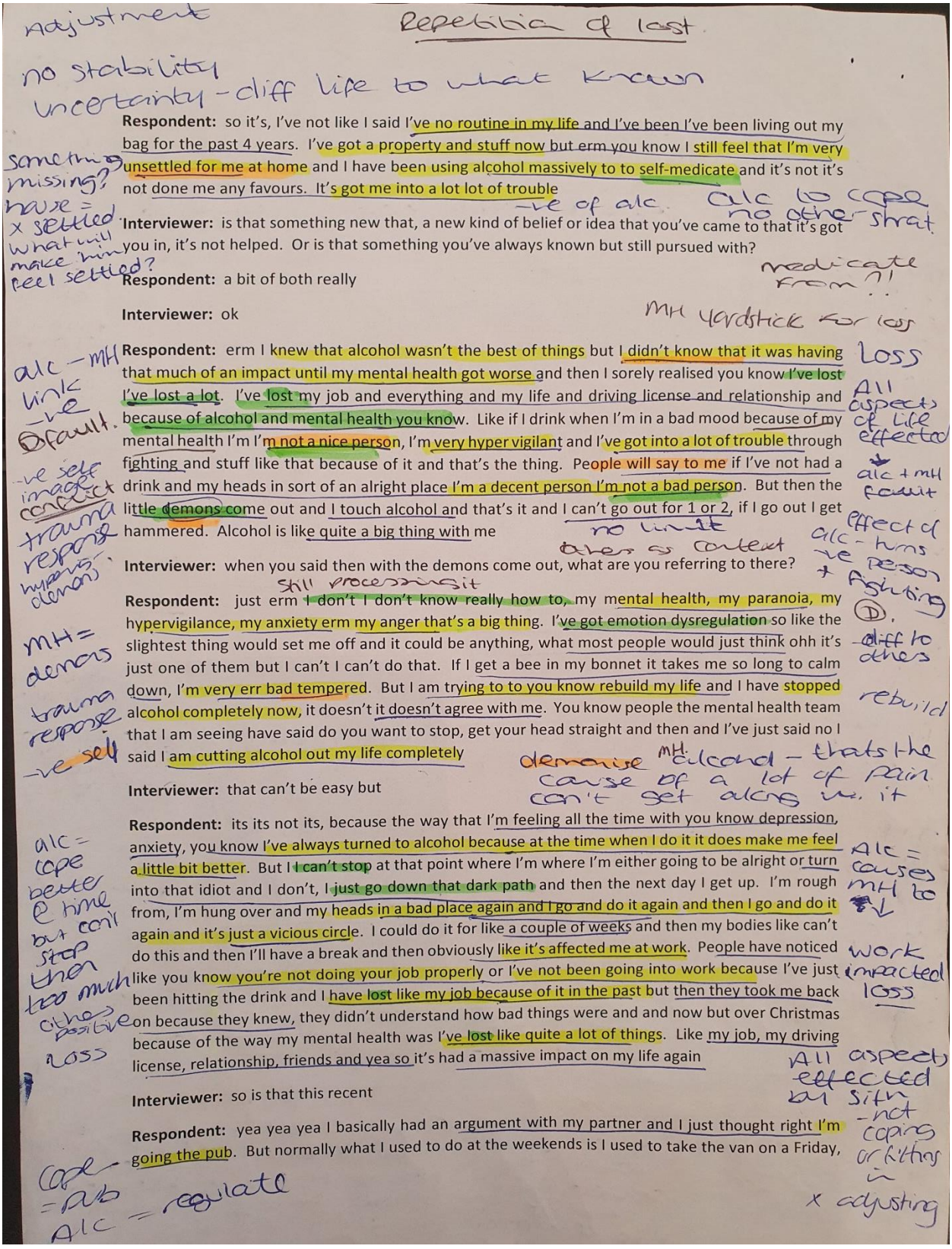
Respondent: erm and yea unfortunately I can't seem to like go, I've no routine in my life at all

Interviewer: yea you said that going into the forces helped kind of brush that, you know the past aside a little bit. Was it the routine and the structure that allowed that?

Respondent: yes I'm I'm used I'm so used to routine and structure I'm used to set times and this and that and tother and just when I've got out into the big wide world and it's not like that and I can't handle it. Erm and when I when I ended up in the hospital for my mental health I was settled because there was routine in the hospital, meals were at set times and erm you know my drugs were at set times and there were things to do and stuff you know things like that were out in civilian street the only thing I've I've known is finish work, go the pub

Interviewer: right ok

EXPERIENCES OF ACCESSING SERVICES



Adjustment

Repetitive of last

no stability

uncertainty - diff life to what known

Respondent: so it's, I've not like I said I've no routine in my life and I've been I've been living out my bag for the past 4 years. I've got a property and stuff now but erm you know I still feel that I'm very unsettled for me at home and I have been using alcohol massively to to self-medicate and it's not it's not done me any favours. It's got me into a lot lot of trouble

-ve of alc

alc to cope no other strat

something missing? house = x settled what will make him feel settled?

Interviewer: is that something new that, a new kind of belief or idea that you've came to that it's got you in, it's not helped. Or is that something you've always known but still pursued with?

Respondent: a bit of both really

medicate from ??

Interviewer: ok

MH yardstick for loss

alc - MH link -ve ⊖fault.

Respondent: erm I knew that alcohol wasn't the best of things but I didn't know that it was having that much of an impact until my mental health got worse and then I sorely realised you know I've lost I've lost a lot. I've lost my job and everything and my life and driving license and relationship and because of alcohol and mental health you know. Like if I drink when I'm in a bad mood because of my mental health I'm I'm not a nice person, I'm very hyper vigilant and I've got into a lot of trouble through fighting and stuff like that because of it and that's the thing. People will say to me if I've not had a drink and my heads in sort of an alright place I'm a decent person I'm not a bad person. But then the little demons come out and I touch alcohol and that's it and I can't go out for 1 or 2, if I go out I get hammered. Alcohol is like quite a big thing with me

Loss

All aspects of life effected

alc + MH fault

-ve self image conflict trauma response hyping demons

no limit

does as content

effect of alc - hms -ve person + fighting ⊖.

Interviewer: when you said then with the demons come out, what are you referring to there?

still processing it

MH = demons trauma response -ve self

Respondent: just erm I don't I don't know really how to, my mental health, my paranoia, my hypervigilance, my anxiety erm my anger that's a big thing. I've got emotion dysregulation so like the slightest thing would set me off and it could be anything, what most people would just think ohh it's just one of them but I can't I can't do that. If I get a bee in my bonnet it takes me so long to calm down, I'm very err bad tempered. But I am trying to to you know rebuild my life and I have stopped alcohol completely now, it doesn't it doesn't agree with me. You know people the mental health team that I am seeing have said do you want to stop, get your head straight and then and I've just said no I said I am cutting alcohol out my life completely

diff to others

rebuild

demonise MH alcohol - that's the cause of a lot of pain can't get along w. it

Interviewer: that can't be easy but

alc = cope better @ time but can't stop then too much

Respondent: its its not its, because the way that I'm feeling all the time with you know depression, anxiety, you know I've always turned to alcohol because at the time when I do it it does make me feel a little bit better. But I I can't stop at that point where I'm where I'm either going to be alright or turn into that idiot and I don't, I just go down that dark path and then the next day I get up. I'm rough from, I'm hung over and my heads in a bad place again and I go and do it again and then I go and do it again and it's just a vicious circle. I could do it for like a couple of weeks and then my bodies like can't do this and then I'll have a break and then obviously like it's affected me at work. People have noticed like you know you're not doing your job properly or I've not been going into work because I've just been hitting the drink and I have lost like my job because of it in the past but then they took me back on because they knew, they didn't understand how bad things were and and now but over Christmas because of the way my mental health was I've lost like quite a lot of things. Like my job, my driving license, relationship, friends and yea so it's had a massive impact on my life again

Alc = causes MH to ↓

work impacted loss

other positive loss

All aspects effected by sitn - not coping or fitting in x adjusting

Interviewer: so is that this recent

Respondent: yea yea yea I basically had an argument with my partner and I just thought right I'm going the pub. But normally what I used to do at the weekends is I used to take the van on a Friday,

Cope = pub Alc = regulate

Appendix H: HRA approval letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Laura Goodwin
Senior Lecturer in Epidemiology of Mental Health and Addiction
University of Liverpool
Department of Psychological Sciences
Room 2.31 Eleanor Rathbone Building
Liverpool
L69 7ZA

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

25 April 2019

Dear Dr Goodwin

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring how veterans with service-related traumatic brain injury, who are drinking at a hazardous or harmful level, experience mental health services**
IRAS project ID:	**255557**
Protocol number:	**UoL001425**
REC reference:	**19/NW/0166**
Sponsor	**University of Liverpool**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **255557**. Please quote this on all correspondence.

Yours sincerely,

Isobel Lyle | Senior Assessor
Health Research Authority
T: 0207 972 2496
Holland Dr, Newcastle upon Tyne NE2 4NQ
Hra.approval@nhs.net or Isobel.lyle@nhs.net
www.hra.nhs.uk

Copy to: *Mr Alex Astor*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Copies of advertisement materials for research participants [Advert]	1	22 January 2019
Evidence of Sponsor Insurance or Indemnity (non NHS Sponsors only) [Insurance from Sponsor]	1	04 March 2019
HRA Schedule of Events [HRA Assessed]	2.0	09 April 2019
HRA Statement of Activities [HRA Assessed]	2.0	09 April 2019
Interview schedules or topic guides for participants [Interview Topic Guide]	3	18 December 2018
Interview schedules or topic guides for participants [Interview Topic Guide]	3	18 December 2018
IRAS Application Form [IRAS_Form_26022019]		26 February 2019
Other [Letter of Support from Military Veterans Service]	1	04 January 2019
Other [Field Supervisor CV]	1	14 February 2019
Other [PHQ9]	1	04 March 2019
Other [Debrief Sheet]	2	05 March 2019
Other [Capacity assessment Tool]	1	05 March 2019
Participant consent form [Tracked Changes]	4.1	16 April 2019
Participant information sheet (PIS) [Tracked Changes]	4.1	16 April 2019
Research protocol or project proposal [Proposal]	6	27 November 2018
Summary CV for Chief Investigator (CI) [CI CV]	1	22 January 2019
Summary CV for student [CGayson CV]	1	08 January 2019
Summary CV for supervisor (student research) [Secondary Supervisor CV]	1	23 January 2019
Validated questionnaire [AUDIT]	1	22 January 2019

Appendix I: Review committee response

D.Clin.Psychology Programme
Division of Clinical Psychology
Whelan Building, Quadrangle
Brownlow Hill
LIVERPOOL
L69 3GB

Tel: 0151 794 5530/5534/5877
Fax: 0151 794 5537
www.liv.ac.uk/dclinpsychol

16 November 2018

Charlotte Gayson
Clinical Psychology Trainee
Doctorate of Clinical Psychology Doctorate Programme
University of Liverpool
L69 3GB

RE: An exploration of how veterans with service-related traumatic brain injury, who are drinking at a hazardous or harmful level, experience mental health services
Trainee: Charlotte Gayson
Supervisors: Laura Goodwin & Warren Donnellan

Dear Charlotte,

Thank you for your notification of minor amendment to your proposal submitted to the Chair of the D.Clin.Psychol. Research Review Committee.

I can now confirm that your amended proposal (version number 6, dated November 2018) meets the requirements of the committee and has been approved by the Committee Chair.

Please take this Chairs Action decision as *final* approval from the committee.

You may now progress to the next stages of your research.

I wish you well with your research project.

Dr Catrin Eames
Vice-Chair D.Clin.Psychol. Research Review Committee.

Appendix J: Reflexive Statement

The lead researcher is a 30-year-old white British female. Prior to conducting this research, she had an interest in alcohol use and brain injury. She had completed research looking at alcohol use and risky behaviour within the general population, and a qualitative analysis of service user involvement within a mental health charity. This paired with working with individuals who are often marginalised from services, has left me with wanting to provide a voice for marginalised populations who often struggle to access and engage with services. The researcher also has previous clinical experience of working with individuals who have experienced a brain injury during a placement on the Clinical Psychology Doctorate. The researcher had no clinical experience of working with military or veteran populations; however, her older brother is currently within the Armed Forces.

Appendix K: Diary excerpt

Interview with Peter – February 2020

During the interview I felt anxious throughout. I was conscious of how I was sat e.g. crossed arms possibly coming across as defensive to Peter and my eye contact. Peter spoke about a barrier between him and staff from non-veteran backgrounds as he does not trust them, but can be overcome eye contact. This made me very aware that I am not from this background, but want to build a rapport. I noted that Peter was sweating a lot throughout which may have been a sign of his anxiety and that is what I was picking up on.

Peter went into great detail about things he saw and was exposed to, more detail than any of the others I have interviewed to date, and maintaining strong eye contact whilst talking about that. I wonder if Peter felt he had to really describe what he saw/experienced to justify the PTSD and difficulties yet maintain his masculine sense. I felt that when I wasn't nodding or anything, he kept going with more detail, possibly wanting recognition from me about how bad it was. I also wonder if that was him letting a non-military member know what it was like and bridge the gap he was talking about and between us with our experiences.

I felt very aware of my position during the interview as someone employed by NHS, when Peter emphasised his beliefs about the lack of veteran support in NHS. Even though he was recruited through the [NE service], he didn't really speak about them. I wonder if the absence is speaking volumes about his thoughts on help-seeking with that service.

It is noted that prior to the interview, I watched the news which covered suicide within veterans, because they reach crisis and do not access services in time, or at all. This really hit home for me about why it is key to explore these experiences, especially as this was mirrored with Peter speaking about having a gun in his mouth. Therefore, this may have influenced me in the interview and contributed to the anxiety and pressure I felt to ensure it was a good interview.